QI TALK TIME

Building an Irish Network of Quality improvers

23 March, 2021

A session with Samantha Riley and Dr Jennifer Martin

Making Data Count

Welcome

- **Sound:** Computer or dial in:
  - **Telephone no: 01-5260058**
  - **Event number: 183 727 7063#**
- **Chat box function**
  - Comments/Ideas
  - Keep the questions coming!
- **Recording**

- **Engage with the team**
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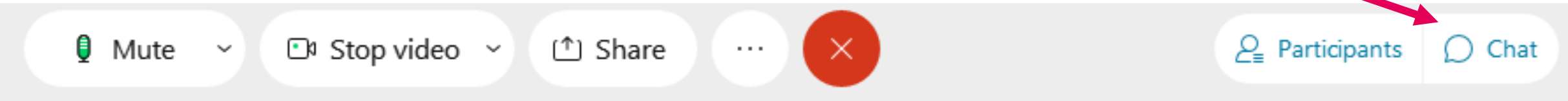
- **New feature**
  - **Short feedback form after the session, please help us to improve our QITalktime Webinars**
  - **A window will pop up before logging out**



Speakers today

Samantha Riley
Deputy Director of Intensive Support
NHS England & NHS Improvement

Dr Jennifer Martin
Specialist in Public Health Medicine
Evidence for Improvement Lead,
National QI Team HSE

Making data count

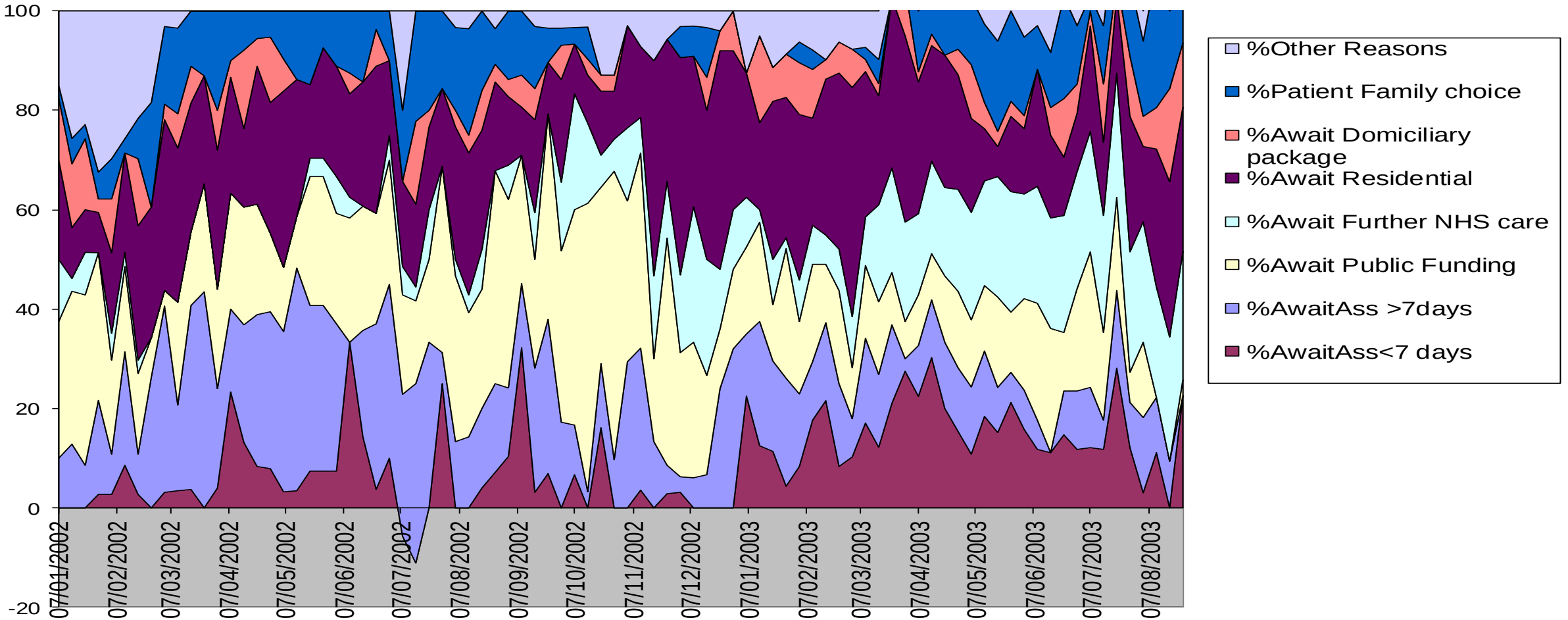
- An introduction

23rd March 2021

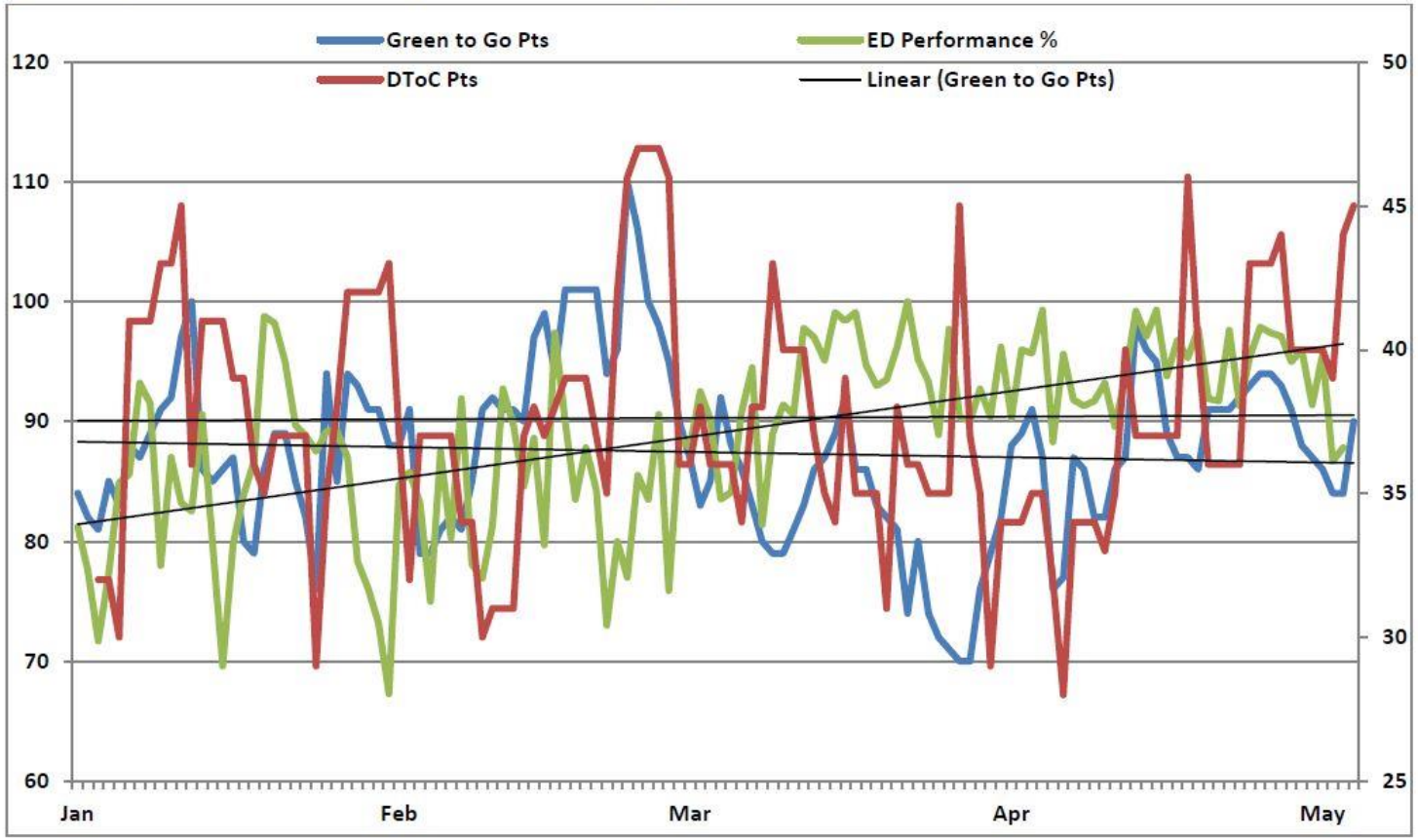
Samantha Riley, Deputy Director of Intensive Support

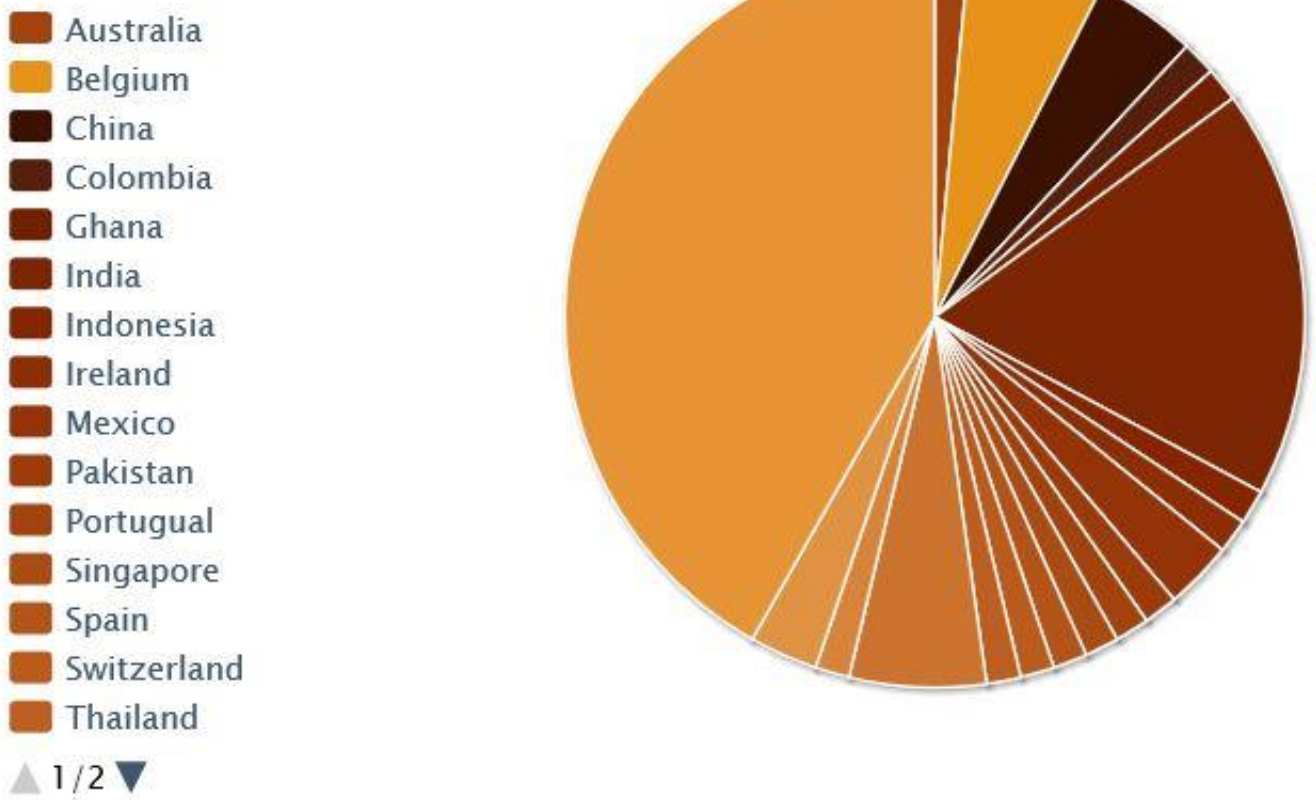
NHS England and NHS Improvement

% Delayed transfers of Care by Type - source SITREPS 7/1/02-31/08/03



Graph 1. ED Performance, Number of Patients with a Delayed Transfer of Care (DTOC) and number of patients categorised as Green to Go




Australia
Belgium
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Mexico
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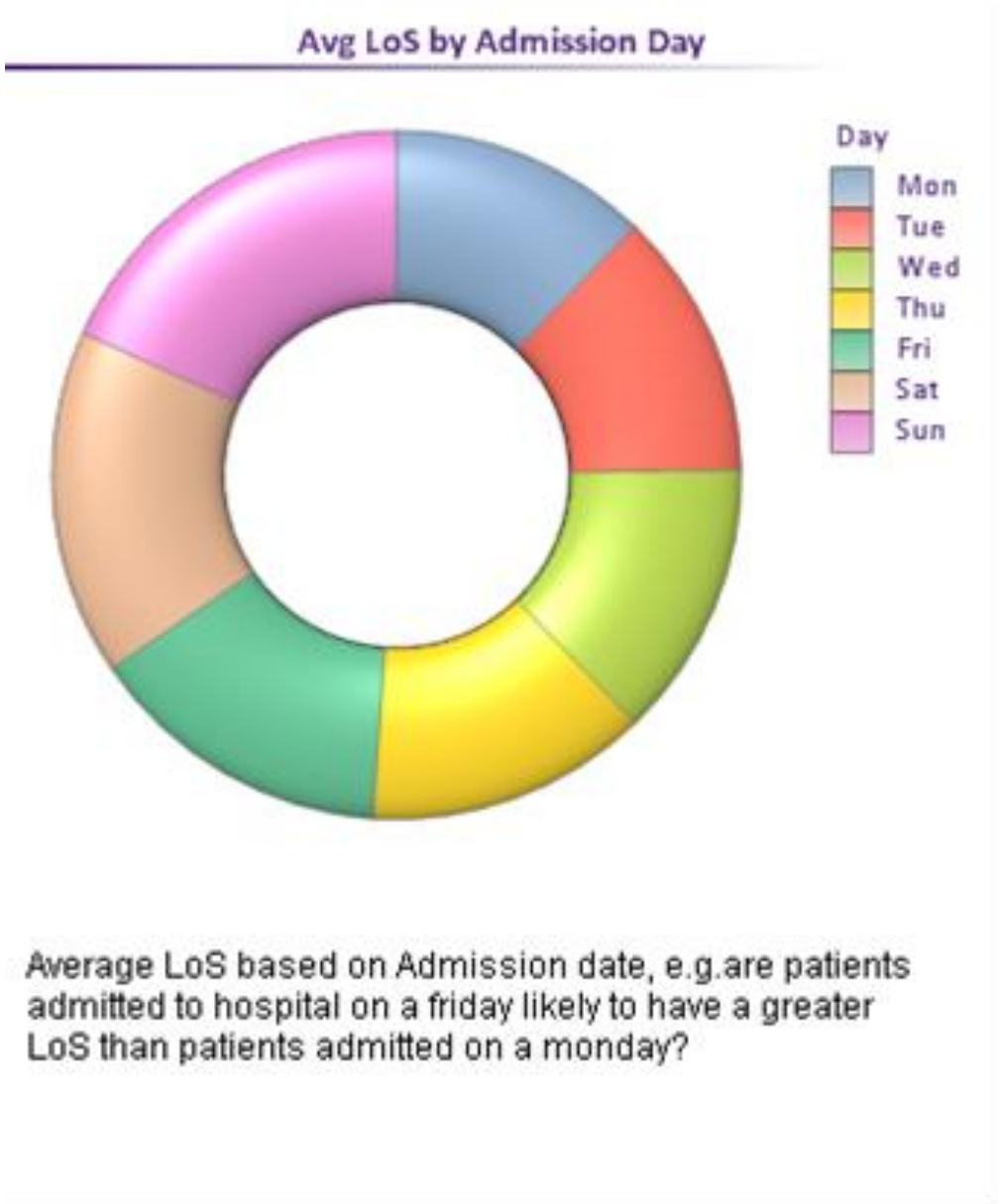
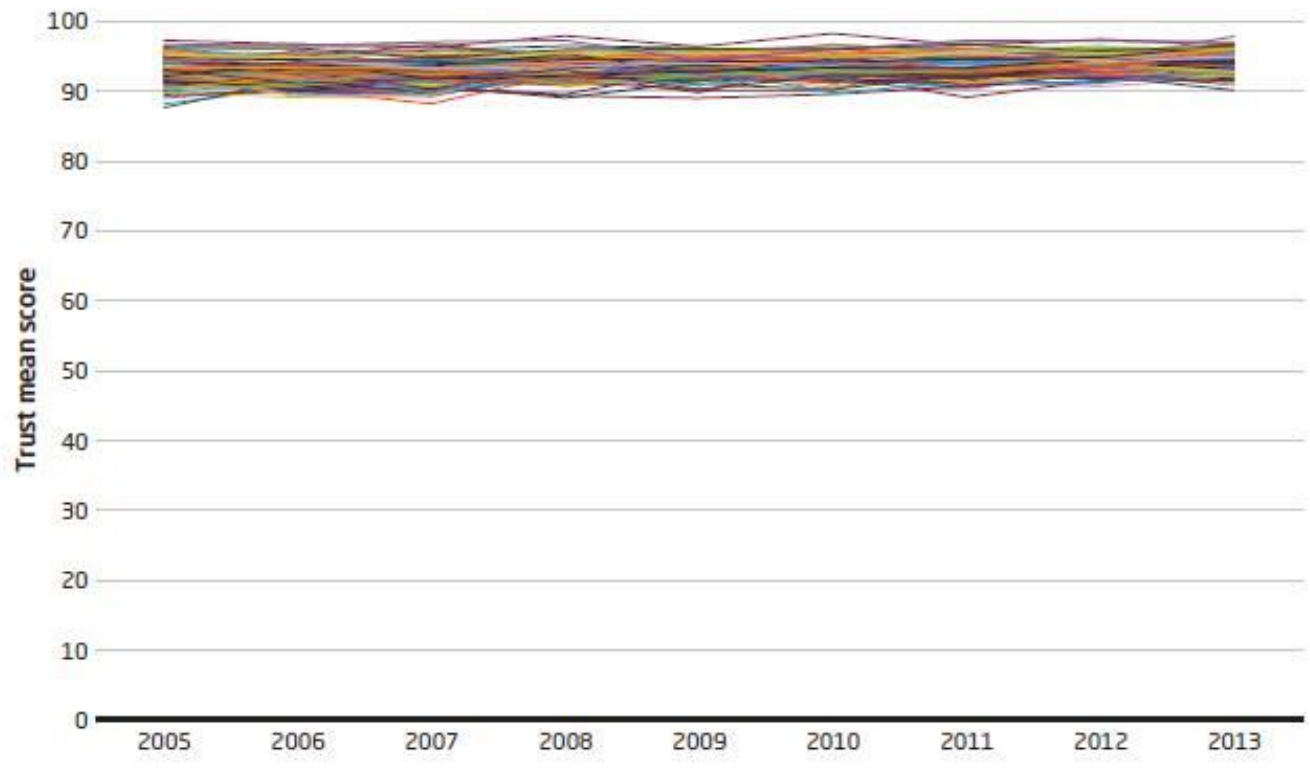


Average LoS based on Admission date, e.g.are patients admitted to hospital on a friday likely to have a greater LoS than patients admitted on a monday?

Figure 2 Annual trends in Q37 (Were you given enough privacy when being examined or treated?) and Q21 (How would you rate the hospital food?)



Where we are now.....

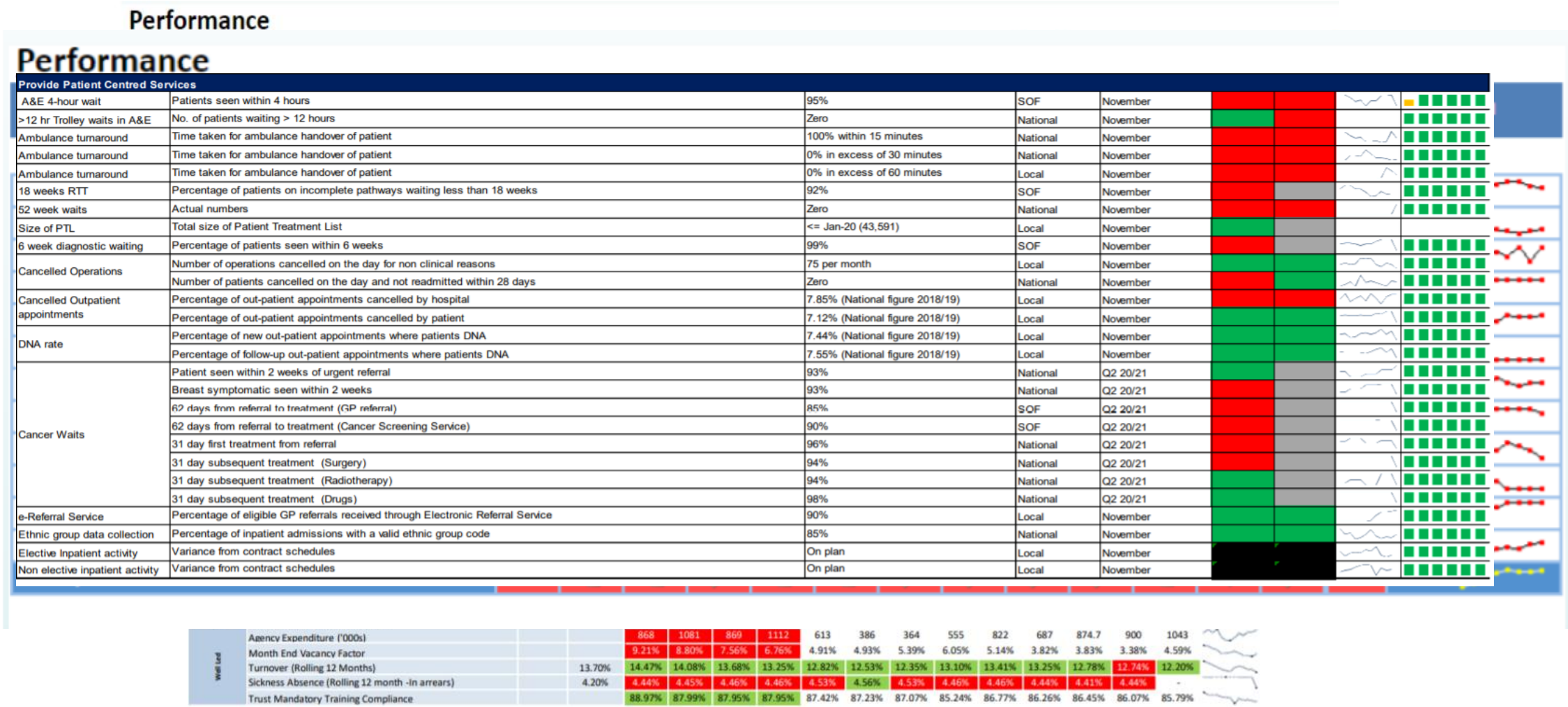
2. TRUST PERFORMANCE OVERVIEW

	Indicator	Objective	Director	Target	Set By	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	17/18	18/19	19/20
Safe	Falls per 1000 occupied bed days resulting in Harm	Patients	LM	<=0.98	QEH	0.08	0.00	0.00	0.00	0.08	0.17	0.08	0.18	0.33	0.09	0.00	0.17	0.24	0.07	0.09	0.12
	Eligible patients having Venous Thromboembolism (VTE) risk assessment	Patients	LM	>= 97.24%	QEH	97.45%	97.28%	97.29%	97.36%	97.57%	97.41%	97.29%	97.36%	97.44%	97.45%	97.31%	97.39%	Data 1 Mth in arrears	97.10%	97.41%	97.38%
	Harm-free QEH Care	Patients	LM	>= 95%	QEH	96.40%	97.22%	97.66%	97.49%	98.77%	98.46%	98.62%	99.18%	96.08%	98.29%	99.54%	98.14%	98.82%	96.84%	97.73%	98.70%
	Never Events	Patients	FS	0	Nat	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	0
	Serious Incidents (OCCURRED IN MONTH)	Patients	FS	0	Nat	1	5	3	3	4	7	6	4	9	3	3	7	5	29	54	18
	Serious Incidents (DECLARED IN MONTH)	Patients	FS	0	Nat	4	1	1	4	3	8	3	8	7	6	4	9	6			25
	Patient safety alerts not completed by deadline	Patients	FS	0	Nat	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
	Clostridium difficile (QEH acquired)	Patients	LM	4	Nat	4	6	1	1	3	2	0	1	0	2	3	4	3	48	22	12
	Clostridium difficile per 100k occupied bed days (rolling 12 months)	Patients	LM	<= 17.6	Nat	28.2	30.3	27.7	23.6	23.0	23.8	21.8	19.3	15.3	14.7	16.2	19.0	18.2	32.4	15.3	18.2
	MRSA bacteraemia (QEH acquired)	Patients	LM	0	Nat	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0
	MRSA bacteraemia per 100k occupied bed days (rolling 12 months)	Patients	LM	0.0		1.3	1.3	1.3	1.4	1.4	1.4	1.4	1.4	1.4	0.0	0.0	0.0	0.0	0.0	1.4	0.0
	Safe staffing levels (overall fill rate)	Patients	LM	>= 80%	Nat	95.6%	93.5%	95.2%	98.7%	98.1%	98.4%	102.6%	101.2%	111.0%	103.3%	103.8%	97.3%	95.5%		98.9%	99.9%
	No. of wards below 80% fill rate	Patients	LM	0	Nat	0	1	0	0	0	0	0	0	0	0	0	0	1		1	1
	Cleanliness Scores - very high-risk areas	Places	LM	>= 100%	Nat	94.71%	93.87%	95.45%	95.10%	94.59%	95.71%	94.60%	95.82%	95.48%	95.63%	95.88%	98.38%	96.63%		95.23%	96.63%
	Cleanliness Scores - high-risk areas	Places	LM	>= 100%	Nat	93.78%	93.89%	93.91%	95.29%	96.08%	93.84%	95.25%	96.03%	95.89%	94.41%	95.94%	97.59%	95.59%		94.88%	95.88%
	Cleanliness Scores - significant-risk areas	Places	LM	>= 100%	Nat	90.88%	92.20%	93.06%	92.85%	92.17%	88.11%	92.10%	92.62%	93.59%	94.19%	94.67%	96.22%	94.64%		91.48%	94.93%
	Cleanliness Scores - low-risk areas	Places	LM	>= 100%	Nat	89.38%	84.52%	90.56%	88.40%	94.43%	0.00%	92.03%	90.01%	96.72%	92.33%	95.50%	88.00%	93.57%		83.24%	92.35%
	No. of cleanliness audits complete	Places	LM	37		46	34	29	45	35	31	47	35	34	44	36	35	46		435	161
Effective	SHMI (Trust Level - Rolling 12 M th position, 6 mths in arrears)	Patients	FS	Not higher than expected	QEH			99.56			99.91		6 months in arrears								
	Crude HSMR Mortality (Trust Level - Rolling 12 M th position, 3 mths in arrears)	Patients	FS	-		3.53	3.46	3.43	3.36	3.35	3.25	3.14	3.09	3.02	Latest Data not avail	3 months in arrears			3.60		
	HSMR (basket of 56 diagnosis groups) (Trust Level - Rolling 12 M th position, 3 months in arrears)	Patients	FS	Not higher than expected	QEH	106.5	106.7	106.9	105.8	105.8	103.2	101.2	100.5	101.5					104.94		
	WEEKEND HSMR (basket of 56 diagnosis groups) (Trust Level - Rolling 12 M th position, 3 months in arrears)	Patients	FS	Not higher than expected	QEH	115.0	114.4	115.3	116.4	114.7	114.5	112.4	109.0	107.4					111.35		
	Rate per 1000 admissions of inpatient cardiac arrests	Patients	FS	< 2.0	QEH	1.65	1.39	1.44	1.31	1.02	2.05	0.90	1.91	0.40	1.70	1.37	0.53	0.72	1.55	1.34	1.08
	Total C Section Rate	Patients	FS	< 25.00%	QEH	34.39%	27.81%	41.71%	30.77%	30.91%	35.63%	32.18%	34.30%	31.61%	31.93%	29.52%	30.72%	1 month in arrears	28.87%	33.47%	30.72%
	Stillbirth Rate(per 1000 births/stillbirths-Rolling 12 M ths)	Patients	FS	< 3.73	QEH	3.21	3.24	4.17	3.76	3.31	3.30	3.29	1.88	2.32	1.88	1.88	2.84		2.71	2.32	3.91
	Neonatal Deaths Rate(per 1000 livebirths-Rolling 12 M ths)	Patients	FS	< 1.06	QEH	0.46	0.46	0.93	0.94	1.90	2.36	2.36	2.82	2.79	2.82	2.83	3.32		0.90	2.79	1.96
	Extended Perinatal Deaths Rate (per 1000 births/stillbirths - Rolling 12 M ths)	Patients	FS	< 4.79	QEH	3.67	3.70	5.09	4.70	5.20	5.66	5.63	4.69	5.10	4.69	4.70	6.15		3.61	5.10	5.86
	%"Term" admissions to the NNU	Patients	FS	3.0%	QEH	Data not available prior to Apr 2019									6.5%	10.3%	5.7%	4.7%			6.7%
	%"Avoidable Term" admissions to the NNU	Patients	FS	0.0%	QEH										36.4%	16.7%	30.0%	9.1%			22.0%
	Maternal Deaths	Patients	FS	0	QEH	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	National Clinical Audits participation rate	Patients	FS	=100%	QEH													97.5%	95%	95%	97.5%
	No. of patients recruited to NIHR studies	Patients	FS	>600 Annually	QEH	74	111	64	67	123	51	37	153	77	37	29	59	29		994	154
Caring	Same Sex accommodation standard breaches	Patients	LM	0	Nat	16	8	9	8	14	2	7	11	4	6	5	3	7	62	93	21
	No. of Complaints (Clinical & Non Clinical)	Patients	LM	<= 20	QEH	36	41	41	36	32	27	41	37	38	34	47	24	38	362	421	143
	Complaints (rate as proportion of activity)	Patients	LM		QEH	0.10%	0.12%	0.12%	0.09%	0.08%	0.09%	0.11%	0.11%	0.11%	0.09%	0.12%	0.07%	0.10%		0.10%	0.10%
	%Complaints responded to within the national standard of six months from receipt of the complaint	Patients	LM	100%	Nat	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%		99.8%	98.8%
	%Complaints responded to within 30 days from receipt of the complaint	Patients	LM	>=90%	QEH	66.67%	71.88%	36.11%	46.34%	54.17%	33.33%	57.14%	46.43%	36.17%	6.90%	21.28%	9.76%	25.58%		41.36%	16.88%
	Reopened complaints (% of total complaints)	Patients	LM	<=15%	QEH	0.00%	0.00%	2.44%	0.00%	3.13%	11.11%	0.00%	0.00%	0.00%	2.94%	6.38%	20.83%	10.53%		1.66%	9.09%
	% eligible patients who have dementia case find applied	Patients	LM	>=90.00%		41.20%	48.32%	40.48%	38.76%	46.98%	45.80%	45.79%	44.66%	43.54%	48.94%	51.46%	50.00%	Data 1 Mth in arrears	60.97%	44.09%	50.17%
	Friends & Family (Inpatients & Daycases)	Patients	LM	>=95%	QEH	95.48%	95.01%	95.50%	95.15%	96.15%	95.17%	95.05%	95.03%	96.21%	97.01%	94.73%	95.80%	96.35%	95.53%	95.53%	95.90%
	Sample Size: Friends & Family (Inpatients & Daycases)	Patients	LM	>=30%	QEH	30.36%	34.62%	34.97%	31.47%	33.05%	28.58%	33.67%	37.26%	37.83%	30.17%	35.67%	31.20%	31.31%	30.33%	33.21%	32.38%
	Friends & Family (Accident & Emergency)	Patients	LM	>=95%	QEH	93.15%	93.21%	90.94%	89.42%	89.80%	89.94%	94.32%	95.32%	90.57%	93.25%	94.92%	92.68%	90.93%	93.12%	91.16%	93.03%
	Sample Size: Friends & Family (Accident & Emergency)	Patients	LM	>=20%	QEH	14.65%	12.96%	8.84%	21.32%	20.81%	14.60%	10.20%	11.59%	11.04%	11.55%	11.70%	7.67%	9.81%	16.98%	13.79%	10.16%
	Friends & Family (Outpatients)	Patients	LM	>=95%	QEH	97.10%	97.72%	96.65%	96.03%	96.79%	97.40%	97.07%	96.88%	97.35%	96.98%	96.17%	97.38%	95.77%	96.78%	97.05%	96.54%
	Sample Size: Friends & Family (Outpatients)	Patients	LM		QEH	6.61%	6.05%	5.88%	6.88%	6.19%	5.73%	7.18%	5.63%	6.82%	6.14%	6.15%	6.13%	7.04%	5.41%	6.42%	6.37%
	Friends & Family (Maternity)	Patients	LM	>=95%	QEH	95.12%	100.00%	100.00%	100.00%	94.74%	94.12%	96.67%	100.00%	93.65%	98.04%	100.00%	100.00%	96.83%	96.90%	96.57%	98.62%
	Sample Size: Friends & Family (Maternity)	Patients	LM	>=15%	QEH	21.24%	14.71%	11.58%	22.94%	23.31%	20.12%	17.05%	21.64%	34.62%	31.68%	35.71%	26.67%	27.63%	15.20%	21.97%	30.19%

CQC Domain - Safe

Indicator	Measure	Standard Year	Standard Month	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	20/21 Year to Date	Group M	Group SS	Group W	Group I	Group PCCT	Group CO
	<= No	41	3.4	3	1	4	3	2	2	4	3	3	2	3	0	3	1	2	3	1	1	11	1	0	0	-	0	-
k)	<= No	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	1	0	0	0	-	0	-
k) - rate per 100,000 bed days	<= Rate2	9.42	9.42	5.44	0.00	5.46	5.49	5.65	15.18	0.00	4.76	4.88	21.01	0.00	7.02	12.15	7.23	13.49	0.00	12.61	10.86	9.19	-	-	-	-	-	-
k) - rate per 100,000 bed days	<= Rate2	94.9	94.9	9.44	17.65	5.46	10.99	22.56	15.18	5.19	14.27	24.39	26.26	16.43	21.05	18.23	28.93	6.75	13.15	18.92	10.86	16.54	-	-	-	-	-	-
	=> %	95	95	81.6	82.5	86.3	77.8	80.6	78.1	78.2	79.1	76.9	79.7	75.5	66.4	77.4	76.2	80.4	75.4	79.3	80.3	77.8	82.9	80.3	90.4	37.5	0.0	-
	=> %	95	95	80.2	81.3	79.5	81.3	67.3	76.0	79.5	76.3	80.0	83.9	78.1	83.9	91.5	92.6	93.6	93.9	92.5	92.5	90.6	92.9	91.4	100.0	-	60.0	-
all Harm Free Care	=> %	95	95	96.3	99.0	95.4	93.7	94.5	98.5	95.4	99.3	98.9	98.7	98.4	-	-	-	-	-	-	-	97.3	-	-	-	-	-	-
eters & UTIs	%	-	-	0.2	0.3	0.1	0.3	0.5	0.5	0.0	0.4	0.0	0.3	0.1	-	-	-	-	-	-	-	0.2	-	-	-	-	-	-
	No	-	-	30	34	26	36	37	34	26	36	33	31	28	32	43	45	42	26	43	40	271	16	13	0	-	11	-
urgent	No	-	-	30	34	26	36	37	34	26	36	33	31	28	32	43	45	42	26	43	40	271	16	13	0	-	11	-
sing for standard DOLS application	No	-	-	5	15	6	11	2	4	3	7	6	7	0	3	3	4	8	6	6	7	37	4	1	0	-	2	-
vious month	No	-	-	5	7	0	4	0	1	1	2	0	5	7	9	8	9	6	3	2	6	43	2	1	0	-	3	-
to LA assessment targets	No	-	-	22	17	11	23	20	22	13	22	18	18	24	30	37	43	35	18	29	25	217	8	9	0	-	8	-
LA disagreed with	No	-	-	1	1	0	2	2	0	1	0	0	2	1	0	0	0	0	0	0	0	0	0	0	0	-	0	-
ved regained capacity did not require LA assessment	No	-	-	0	4	3	0	0	0	0	0	1	0	0	0	0	0	0	0	4	0	4	0	0	0	-	0	-
	No	-	-	89	89	86	92	78	-	71	88	97	84	110	66	67	70	74	81	82	74	514	44	5	1	-	24	-
	<= No	0	0	3	2	2	0	0	-	2	0	1	1	0	0	1	1	2	1	0	0	5	0	0	0	0	0	0
	<= Rate1	5	5	4.20	3.97	3.86	4.32	3.76	-	3.22	3.80	4.19	3.94	5.66	4.33	4.54	4.62	4.58	4.84	4.66	3.76	4.46	-	-	-	-	-	-
ired - Total	<= No	0	0	28	28	26	28	33	23	14	32	36	39	32	38	32	19	23	20	25	32	189	23	7	-	-	2	-
d Bed Days	Rate1	-	-	1.37	1.34	1.16	1.27	1.54	0.97	0.61	1.32	1.50	1.77	1.59	2.44	2.10	1.22	1.38	1.16	1.38	1.58	1.59	-	-	-	-	-	-
ired - Total	<= No	0	0	16	24	29	35	27	31	18	25	25	26	22	20	24	25	41	29	24	22	185	-	-	-	-	22	-
ion to SWBH	<= No	0	0	130	141	125	87	85	78	95	88	104	117	102	109	100	96	114	112	93	124	747	-	-	-	-	-	-
Assessments	=> %	95	95	96.0	95.7	95.9	95.2	95.6	96.3	-	95.9	96.0	96.0	95.3	94.9	95.0	96.2	96.2	95.3	95.5	95.3	95.6	97.5	93.7	91.3	95.7	98.5	-
tions (%pts where all sections complete)	=> %	100	100	-	100.0	100.0	100.0	-	100.0	99.0	100.0	99.3	99.6	100.0	99.8	100.0	100.0	100.0	99.9	99.3	100.0	100.0	100.0	100.0	99.7	-	100.0	-
where complete)	=> %	100	100	100.0	99.8	100.0	99.8	100.0	100.0	100.0	100.0	100.0	99.6	100.0	100.0	100.0	100.0	100.0	100.0	100.0	99.7	100.0	100.0	100.0	-	-	100.0	-
Apr 19 WHO Safer Surgery - Audit - brief and debrief (% lists where complete)	=> %	100	100	100.0	99.8	99.8	99.6	100.0	99.7	100.0	99.3	100.0	99.8	99.3	100.0	100.0	100.0	98.7	99.3	100.0	99.2	99.5	100.0	98.2	-	-	100.0	-
Never Events	<= No	0	0	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Medication Errors causing serious harm	<= No	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	-
Serious Incidents	<= No	0	0	3	12	12	12	11	17	11	7	6	8	0	4	8	12	6	7	10	7	54	3	1	3	0	0	0
Open Central Alert System (CAS) Alerts	No	-	-	15	4	9	8	11	12	10	12	10	9	8	2	5	3	3	5	6	4	28	-	-	-	-	-	-
Open Central Alert System (CAS) Alerts beyond deadline date	<= No	0	0	7	3	6	5	6	7	2	1	1	0	0	0	0	0	0	0	0	0	0	-	-	-	-	-	-
Sepsis - Screened (as % Of Screening Required)	=> %	100	100	-	-	-	-	-	-	-	88.5	91.1	90.7	92.8	95.4	94.7	96.2	94.4	94.5	96.1	97.4	95.6	96.9	99.6	96.4	-	97.4	-
Sepsis - Screened Positive (as % Of Screened)	%	-	-	-	-	-	-	-	-	-	16.2	16.3	17.6	19.6	20.2	21.1	20.8	22.8	22.9	23.5	22.9	21.7	24.2	17.5	11.1	-	13.2	-
Sepsis - Treated (as % Of Screened Positive)	%	-	-	-	-	-	-	-	-	-	80.3	77.1	75.7	79.6	82.7	72.1	72.8	82.9	87.9	89.7	88.3	80.9	89.8	82.6	66.7	-	60.0	-
Sepsis - Treated in 1 Hour (as % Of Treated)	=> %	100	100	-	-	-	-	-	-	-	54.9	51.9	60.0	53.9	57.2	64.2	58.2	57.1	56.1	81.0	80.4	65.2	61.8	79.0	100.0	-	33.3	-
Sepsis - Antibiotic Review Within 72 hrs	=> %	100	100	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Do you see things like this?



Performance

Performance

Provide Patient Centred Services							
A&E 4-hour wait	Patients seen within 4 hours	95%	SOF	November			
>12 hr Trolley waits in A&E	No. of patients waiting > 12 hours	Zero	National	November			
Ambulance turnaround	Time taken for ambulance handover of patient	100% within 15 minutes	National	November			
Ambulance turnaround	Time taken for ambulance handover of patient	0% in excess of 30 minutes	National	November			
Ambulance turnaround	Time taken for ambulance handover of patient	0% in excess of 60 minutes	Local	November			
18 weeks RTT	Percentage of patients on incomplete pathways waiting less than 18 weeks	92%	SOF	November			
52 week waits	Actual numbers	Zero	National	November			
Size of PTL	Total size of Patient Treatment List	<= Jan-20 (43,591)	Local	November			
6 week diagnostic waiting	Percentage of patients seen within 6 weeks	99%	SOF	November			
Cancelled Operations	Number of operations cancelled on the day for non clinical reasons	75 per month	Local	November			
	Number of patients cancelled on the day and not readmitted within 28 days	Zero	National	November			
Cancelled Outpatient appointments	Percentage of out-patient appointments cancelled by hospital	7.85% (National figure 2018/19)	Local	November			
	Percentage of out-patient appointments cancelled by patient	7.12% (National figure 2018/19)	Local	November			
DNA rate	Percentage of new out-patient appointments where patients DNA	7.44% (National figure 2018/19)	Local	November			
	Percentage of follow-up out-patient appointments where patients DNA	7.55% (National figure 2018/19)	Local	November			
Cancer Waits	Patient seen within 2 weeks of urgent referral	93%	National	Q2 20/21			
	Breast symptomatic seen within 2 weeks	93%	National	Q2 20/21			
	62 days from referral to treatment (GP referral)	85%	SOF	Q2 20/21			
	62 days from referral to treatment (Cancer Screening Service)	90%	SOF	Q2 20/21			
	31 day first treatment from referral	96%	National	Q2 20/21			
	31 day subsequent treatment (Surgery)	94%	National	Q2 20/21			
	31 day subsequent treatment (Radiotherapy)	94%	National	Q2 20/21			
	31 day subsequent treatment (Drugs)	98%	National	Q2 20/21			
e-Referral Service	Percentage of eligible GP referrals received through Electronic Referral Service	90%	Local	November			
Ethnic group data collection	Percentage of inpatient admissions with a valid ethnic group code	85%	National	November			
Elective Inpatient activity	Variance from contract schedules	On plan	Local	November			
Non elective inpatient activity	Variance from contract schedules	On plan	Local	November			

Well Led															
	Agency Expenditure ('000s)			868	1081	869	1112	613	386	364	555	822	687	874.7	900	1043
	Month End Vacancy Factor			9.21%	8.80%	7.56%	6.76%	4.91%	4.93%	5.39%	6.05%	5.14%	3.82%	3.83%	3.38%	4.59%
	Turnover (Rolling 12 Months)		13.70%	14.47%	14.08%	13.68%	13.25%	12.82%	12.53%	12.35%	13.10%	13.41%	13.25%	12.78%	12.74%	12.20%
	Sickness Absence (Rolling 12 month -In arrears)		4.20%	4.44%	4.45%	4.46%	4.46%	4.53%	4.56%	4.53%	4.46%	4.46%	4.44%	4.41%	4.44%	-
	Trust Mandatory Training Compliance			88.97%	87.99%	87.95%	87.95%	87.42%	87.23%	87.07%	85.24%	86.77%	86.26%	86.45%	86.07%	85.79%

The importance of focus

Safety & Quality Dashboard		Mar 2018							
CQC Domain	Indicator	Previous Period	Previous Value	Latest Period	Latest Value	Difference	Trend over previous period	Trend - APR 2017 onwards	2017/18 Total / 2017/18 Average
	Emergency Care - Friends and Family Test - Would Recommend	January 2018	93.27%	February 2018	95.73%	2.46%	▲		94.32%

One month trend…….

Is an increase from 95.36% to 95.76% important or distracting narrative?

Caring

7 Family and Friends Test (FFT) (data up to February 2018)

7.2 The Trusts 'Would Recommend' for Friends and Family returns *increased* to 95.76% for February 2018 from 95.36% in January 2018. The percentage of patients who stated they 'Wouldn't Recommend' *decreased* to 0.85% in February 2018 from 1.07% in January 2018.


J
Q
K

An abundance of comments…..

a slight decrease from 5.25% to 5.23%

slightly deteriorated from 65.96% in June compared to 64.60% in July.

deteriorated from 81.77% in June to 81.14% in July.

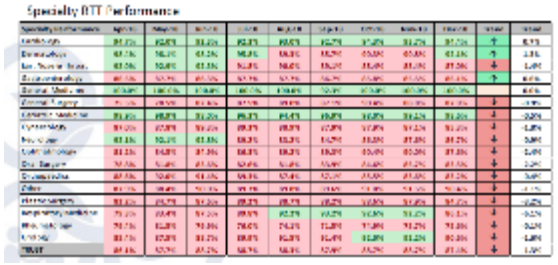
deteriorated from 4.54% in June to 5.17% in July.

performance deteriorated from 84.67% in June to 81.12% in July.

Specialty RTT Performance

Specialty Performance	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Trend	Trend
Cardiology	94.7%	92.0%	92.3%	92.3%	93.0%	92.7%	94.3%	93.7%	94.4%	↑	0.7%
Dermatology	98.4%	98.1%	98.2%	95.8%	89.3%	85.7%	90.3%	90.8%	92.1%	↑	1.3%
Ear, Nose & Throat	92.0%	92.9%	92.3%	91.8%	90.0%	89.1%	88.4%	88.4%	87.0%	↓	-1.4%
Gastroenterology	86.5%	87.7%	86.3%	87.7%	87.7%	86.7%	85.8%	85.5%	86.1%	↑	0.6%
General Medicine	100.0%	100.0%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%		0.0%
General Surgery	75.5%	78.5%	82.4%	87.5%	89.0%	87.1%	90.4%	88.8%	87.9%	↓	-0.9%
Geriatric Medicine	98.9%	98.9%	98.0%	96.3%	94.4%	96.9%	98.0%	99.1%	98.6%	↓	-0.5%
Gynaecology	87.0%	87.8%	89.3%	89.3%	88.9%	87.9%	87.9%	87.1%	85.3%	↓	-1.8%
Neurology	92.1%	92.1%	92.8%	89.2%	83.2%	84.7%	86.3%	87.6%	86.7%	↓	-0.9%
Ophthalmology	81.2%	84.5%	84.9%	86.3%	89.2%	89.3%	90.4%	90.0%	87.6%	↓	-2.4%
Oral Surgery	78.8%	81.8%	83.6%	82.6%	81.8%	83.9%	84.6%	85.7%	83.5%	↓	-2.2%
Orthopaedics	88.6%	92.0%	91.4%	89.3%	87.4%	87.1%	85.5%	83.6%	83.2%	↓	-0.4%
Other	87.9%	88.4%	90.0%	89.7%	89.8%	89.6%	91.0%	91.5%	90.4%	↓	-1.1%
Plastic Surgery	82.2%	84.7%	87.6%	89.2%	88.7%	88.2%	88.6%	87.9%	84.7%	↓	-3.2%
Respiratory Medicine	79.3%	83.4%	87.5%	89.8%	92.2%	93.2%	92.6%	92.2%	86.1%	↓	-6.1%
Rheumatology	79.4%	81.5%	79.9%	76.0%	74.1%	71.5%	74.9%	75.7%	75.6%	↓	-0.1%
Urology	85.4%	87.5%	88.7%	89.9%	91.5%	91.4%	92.0%	92.2%	90.6%	↓	-1.6%
TRUST	86.1%	87.7%	88.7%	88.7%	88.3%	87.9%	88.7%	88.7%	87.4%	↓	-1.3%

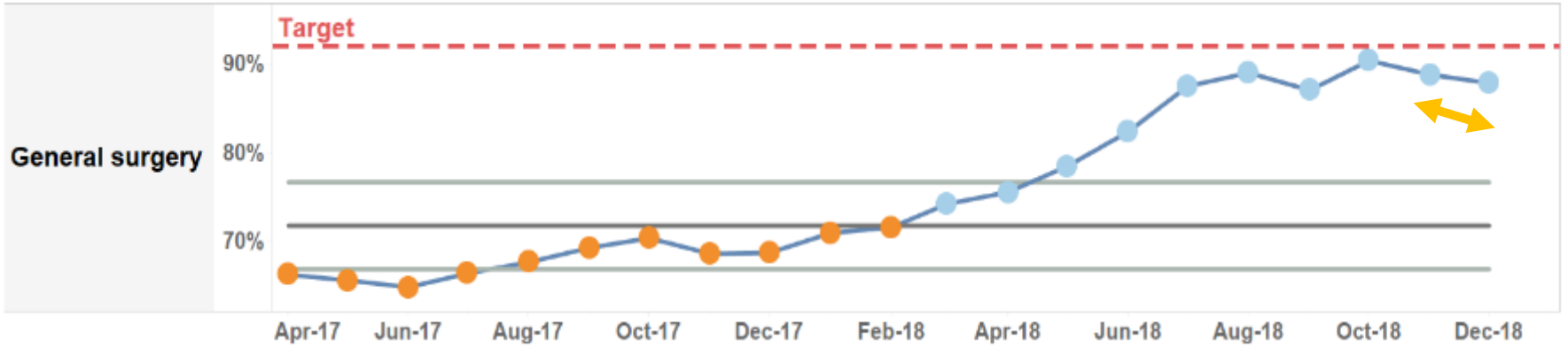
SPC analysis



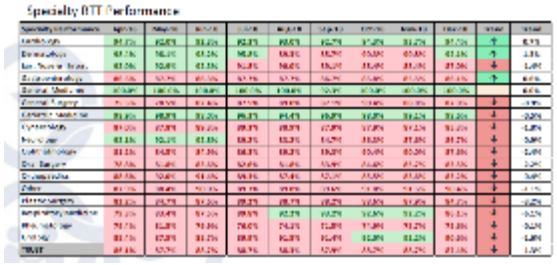
General Surgery

General Surgery	75.5%	78.5%	82.4%	87.5%	89.0%	87.1%	90.4%	88.8%	87.9%	↓	-0.9%

Decline & Failing?



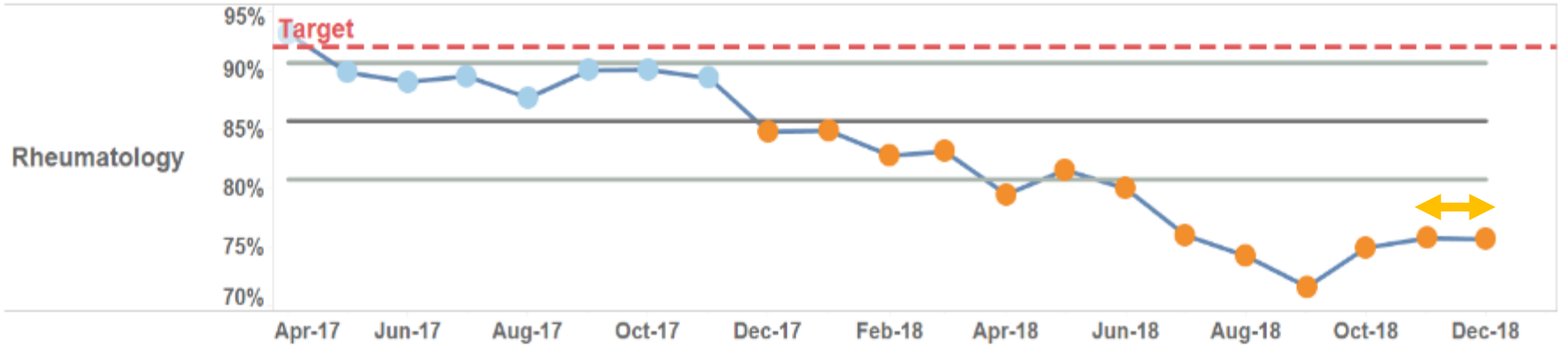
SPC analysis



Rheumatology

Rheumatology	79.4%	81.5%	79.9%	76.0%	74.1%	71.5%	74.9%	75.7%	75.6%	↓	-0.1%

Same misinterpretation as before?

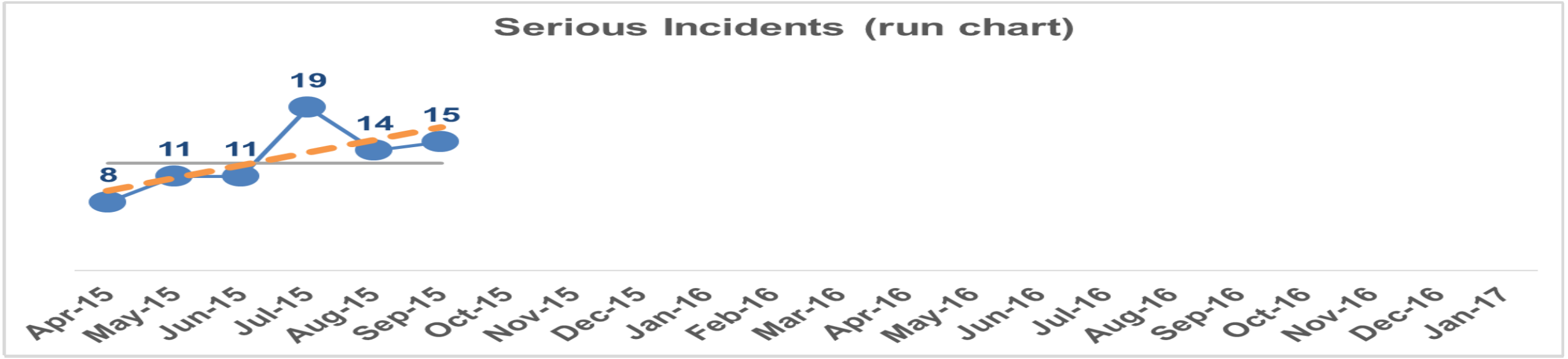


Scenario

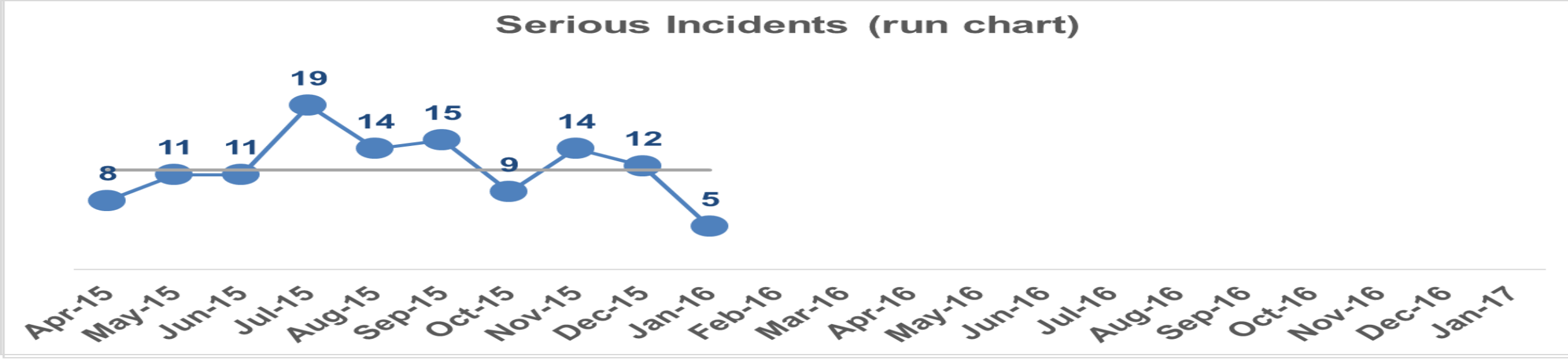
We’re going to simulate some **real data** in a healthcare setting

We’ll be thinking about **how people react to patterns and trends** in data.

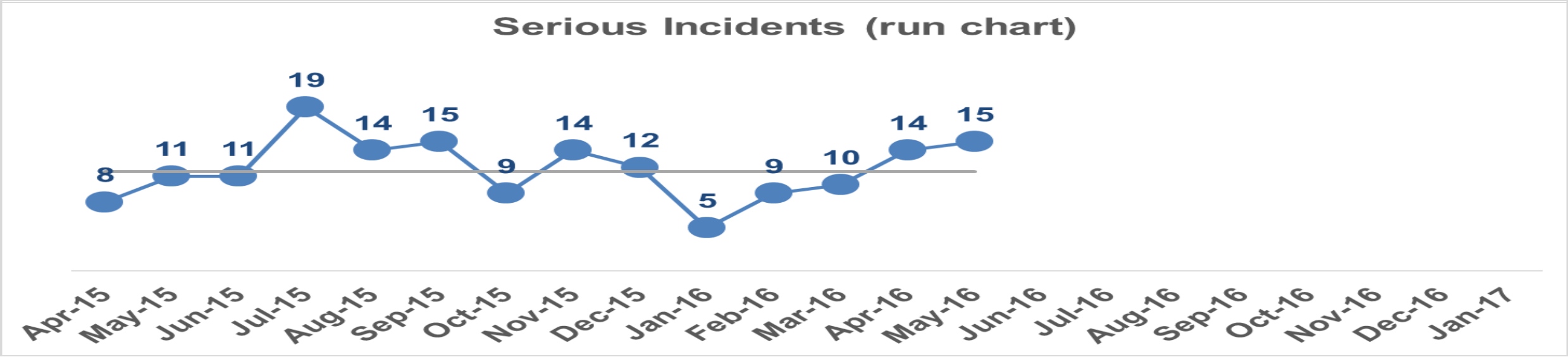
Can you spot an **improvement or decline** when it occurs?



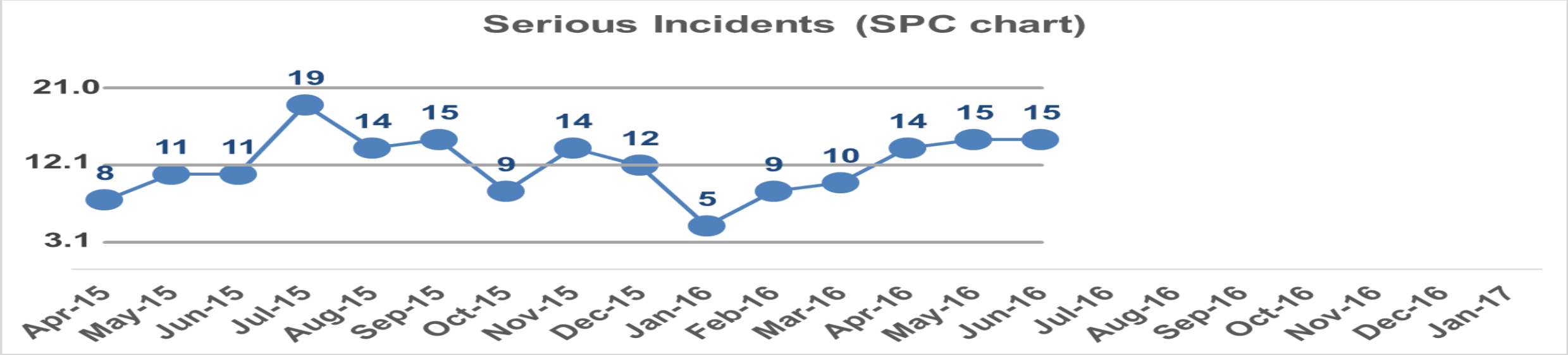
What might a linear trend line show?
What's your impression – increase, decline or no change?



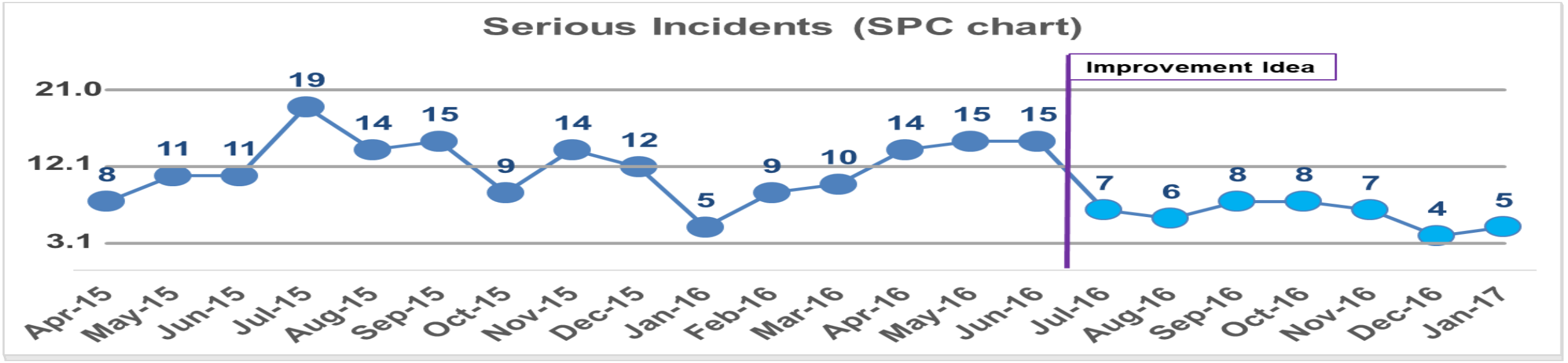
Lowest recorded value.
Has something good happened?



Negative trend of four
Has something bad happened?

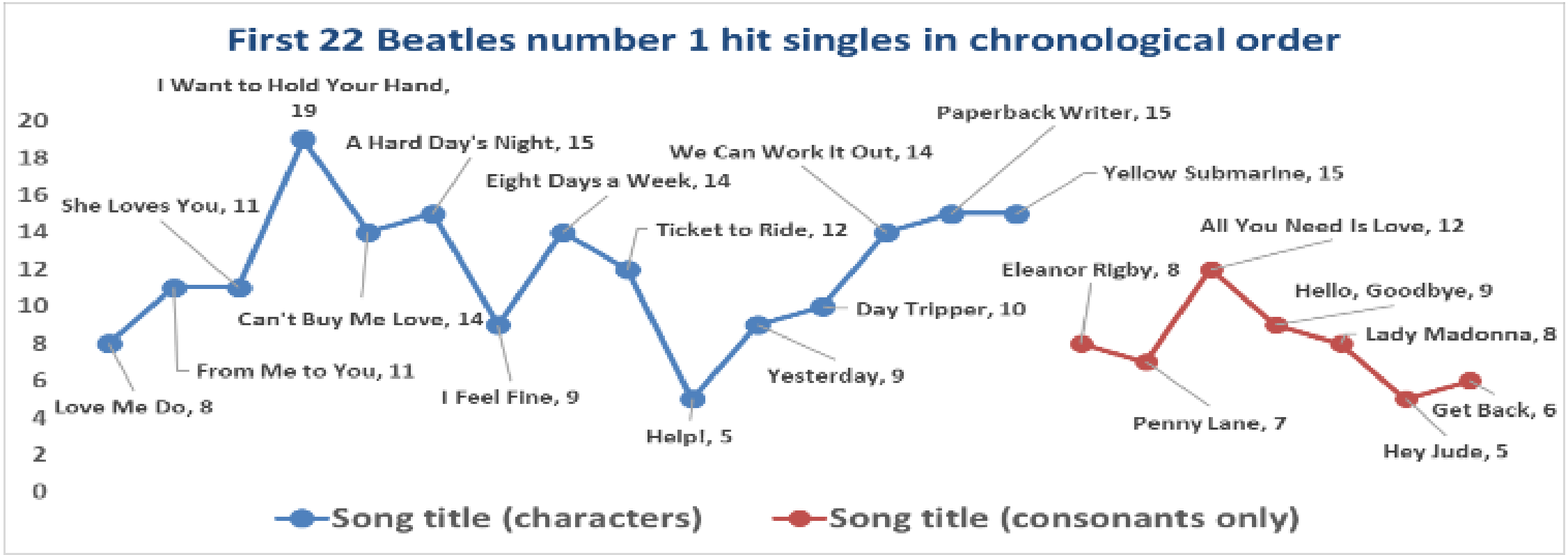


An improvement idea is now implemented.
At what point, if ever, are you confident it has succeeded?



Seven months of success?

What were we trying to show?



Random data creates patterns – so when should we act…

Frequently seen in the NHS

To mak
as if th

Are you spuddling?

Strong evidence base

THE PROBLEM WITH...

The problem with red, amber, green: the need to avoid distraction by random variation in organisational performance measures

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Accepted 18 January 2016
Published Online First 31 March 2016

'The Problem with...' series covers controversial topics related to efforts to improve healthcare quality, including widely recommended but deceptively difficult strategies for improvement and pervasive problems that seem to resist solution.

INTRODUCTION

Many healthcare organisations now track a number of performance measures like infection and complication rates, waiting times, staff adherence to guidelines, etc. Our own organisation, The Capital Region of Denmark, provides healthcare for 1.7 million people and runs 6 hospitals and 11 mental health centres. Measures of clinical quality have been widely used in our region locally at hospitals and departments for many years. Recently, our region started to systematically define and track strategical key performance measures also at the top management level. Approximately 25 measures on a wide range of subjects from hospital infections to public transportation are being tracked by the top management and the Regional Council.

The measurement strategy for hospitals involves a bottom-up approach allowing each hospital and department to, if needed, define its own performance measures that feed into one or more of the overall measures. For example, bacteraemia is one of the overall measures, and some acute-care departments, who rarely see hospital-acquired bacteraemia, have started to work on reducing the use of bladder catheters in order to reduce the risk of bacteraemia from catheter-related urinary tract infections diagnosed after their patients have been transferred to other departments. To support their work, they have developed a handful of measures that track the use of catheters and staff compliance with standard procedures related to catheter use.

We welcome this development very much. The choice of relatively few overall measures combined with the bottom-up approach is a helpful strategy that focuses and aligns improvement work and stimulates the use of data at all levels of the organisation while leaving room for meaningful local adaptations of performance measures.

However, we do not at all welcome the widespread use of red, amber, green approaches to data analysis that is everywhere in our organisation.

By 'red, amber, green', we are referring to graphical data displays that use colour coding of individual data values based on whether this value is on the right (green) or wrong (red) side of a target value. Often amber or yellow is used to indicate data values that are somewhere between 'right' and 'wrong'.

The problem with red, amber, green management is that at best is it useless, at worst it is harmful.

THE PROBLEM WITH RED, AMBER, GREEN

Figure 1 was captured from the February 2015 report on regional performance measures. It shows the monthly count of a certain type of unwanted incident in mental healthcare. The horizontal line represents the target value of 10.5. That is, we do not want more than 10 incidents per month. Red bars show months above target. Green bars show months below target.

The data display in figure 1 is formally correct (green is better than red). However, it fails to convey a very

Linked

► http://dx.doi.org/10.1136/bmjqs-2015-004467
► http://dx.doi.org/10.1136/bmjqs-2016-005303

CrossMark

To cite: Anhøj J, Hellesøe A-MB. BMJ Qual Saf 2017;26:81–84.

EDITORIAL

From stoplight reports to time series: equipping boards and leadership teams to drive better decisions

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Accepted 7 March 2016
Published Online First 31 March 2016

One of us was shown a letter received by a hospital infection control leader from the CEO congratulating her on an excellent monthly performance—for the previous month MRSA infections had decreased from 4 to 2 cases. A couple of months later the same CEO sent a letter expressing serious concern, asking for an explanation of why the monthly MRSA cases had doubled from 2 to 4. Implicit in the CEO's letter is an all too common misunderstanding when using point-to-point data comparisons that every data point is a signal of meaningful change. Absent any information about or understanding of the nature and extent of the underlying variation of the process or event type being analysed, in point-to-point comparisons the only thing one can be sure of is that the second data point will likely be either higher or lower than the preceding data point.

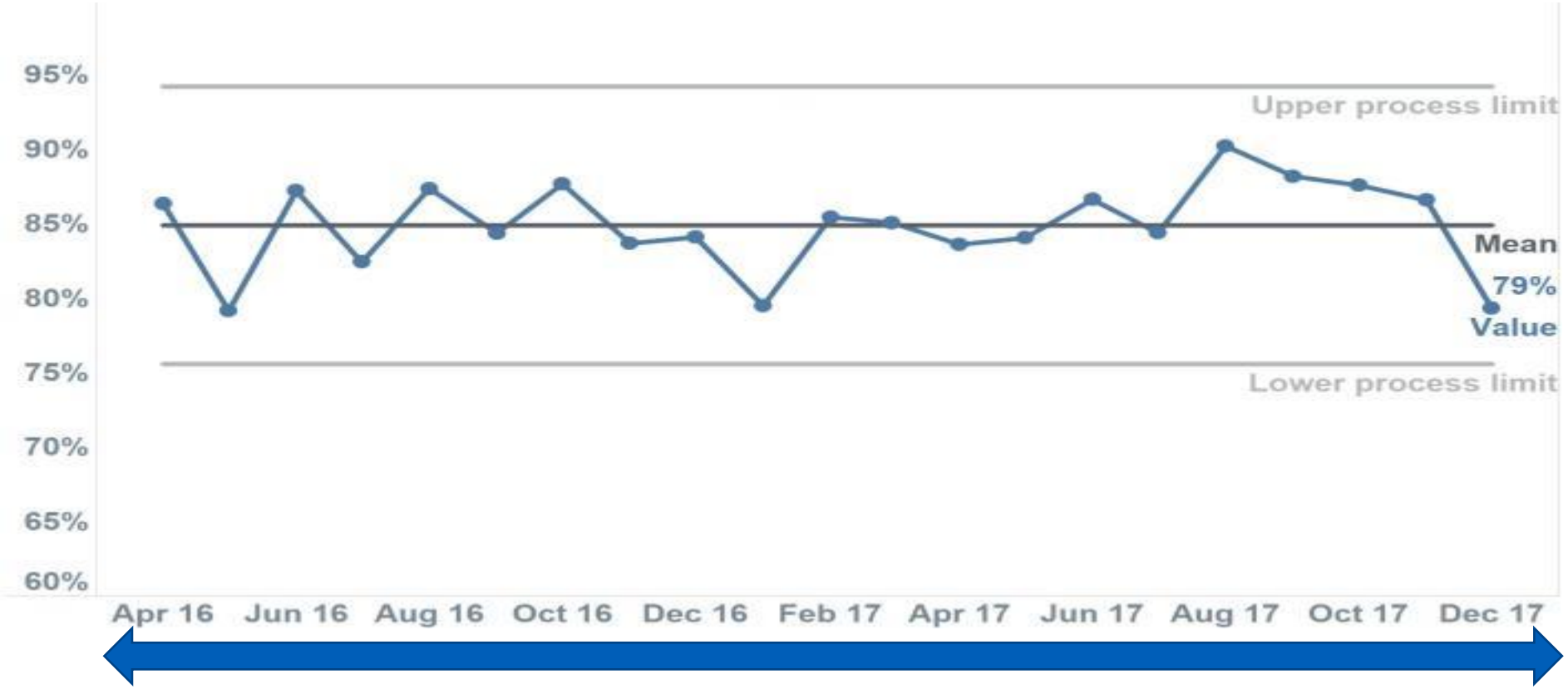
Common to board members, corporate-suite executives, directors and managers is the need to rapidly interpret key data and to decide what if any actions are needed. Two papers in this edition highlight the critical need to ensure that such data presentations do not lead decision-makers astray. In the first paper by Schmidtke *et al*,[1] analysing data presented to Boards of English NHS isolation. Together these two papers are useful contributions to a literature about what forms of data decision-making groups should see in order to focus attention on the most pressing areas, to understand the causes that underpin what the data show, and determine what action should follow. The central question is: how to get data to decision-makers in a form which drives the most useful decision-making?

Anhøj *et al* make the striking claim that red, amber, green management reporting is at best useless and at worst harmful. These reports rely on the simple colour-coded heuristic of 'green is good... proceed as is', 'yellow or amber is warning...proceed with caution' and 'red is bad...stop and take action'. We think their critique is a bit too stark: there are situations when application of the stoplight type reporting may be appropriate. For example, in situations in which process reliability should be 100%—for example, as with never events—each data point can represent a meaningful signal. Likewise for well understood, tightly controlled processes with little inherent variation, stoplight reports may be of value. The primary advantage of stoplight reports is their simplicity and ease with which a large amount of information can be quickly presented.

Linked

The anatomy of a SPC chart

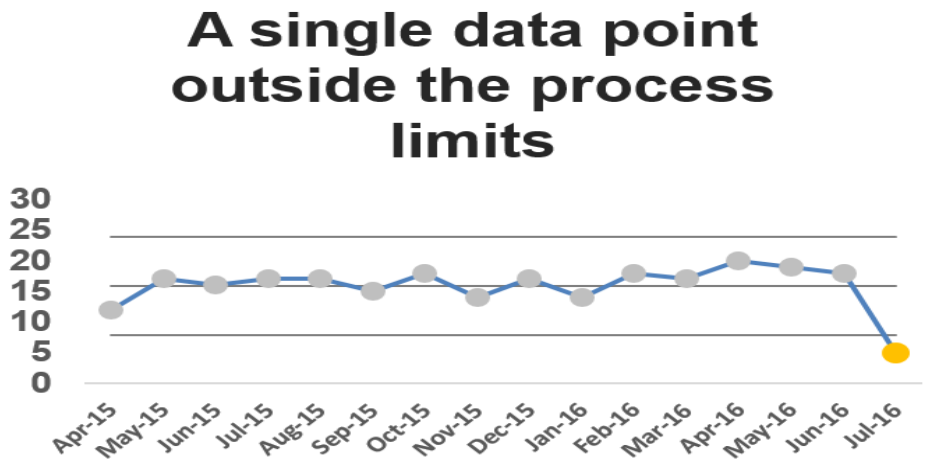
Time series line chart with 3 reference lines

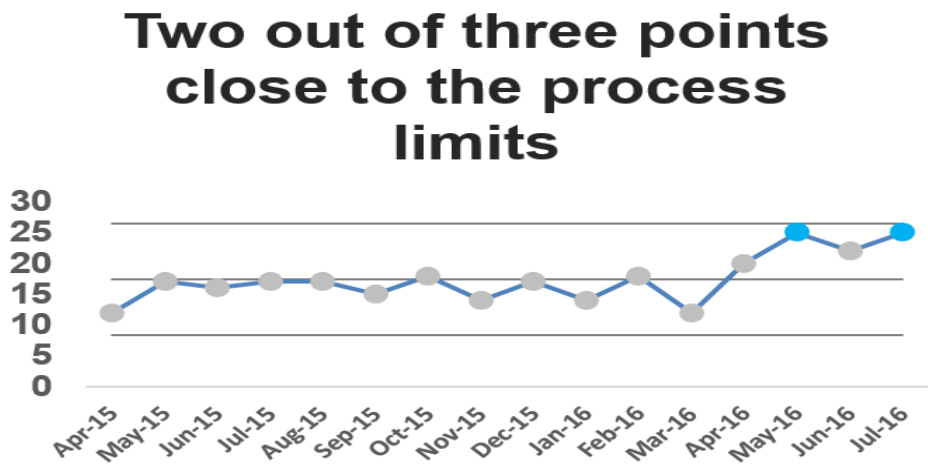


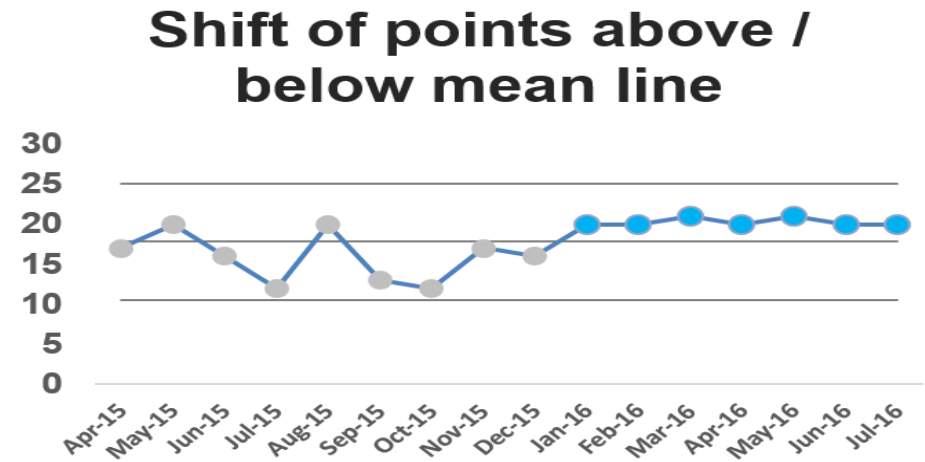
≈ 99% of data

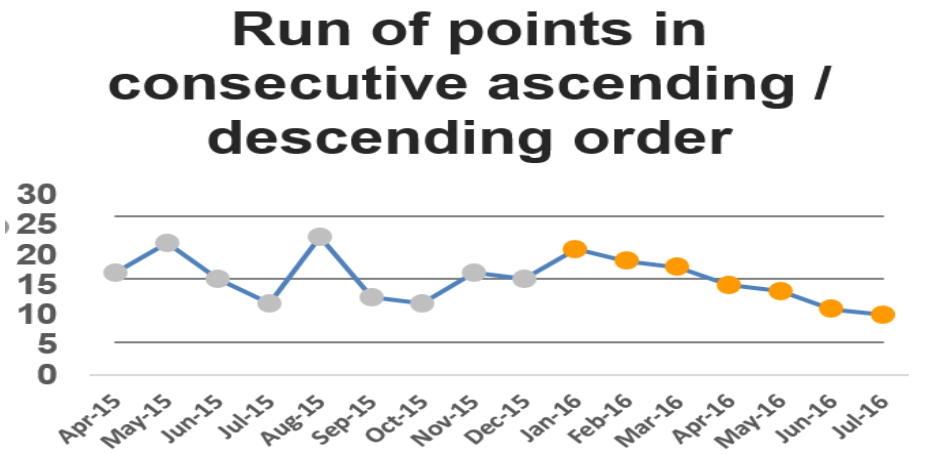
15+ data points for a robust analysis

SPC rules : special cause variation

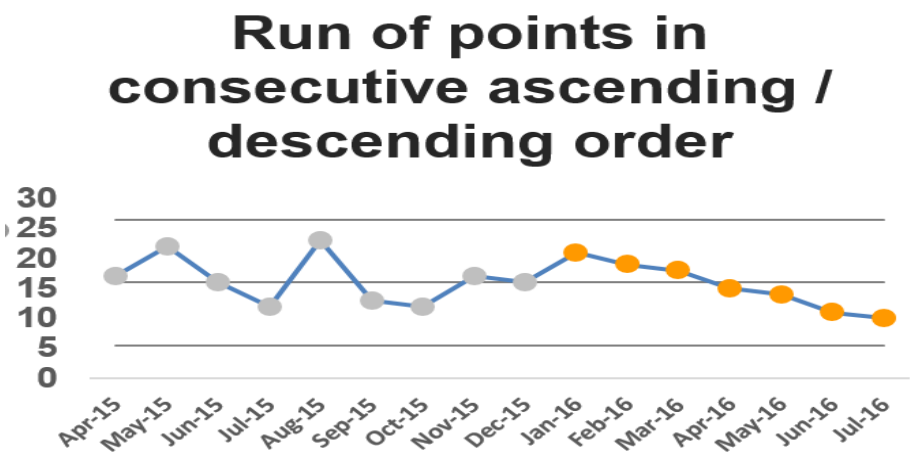




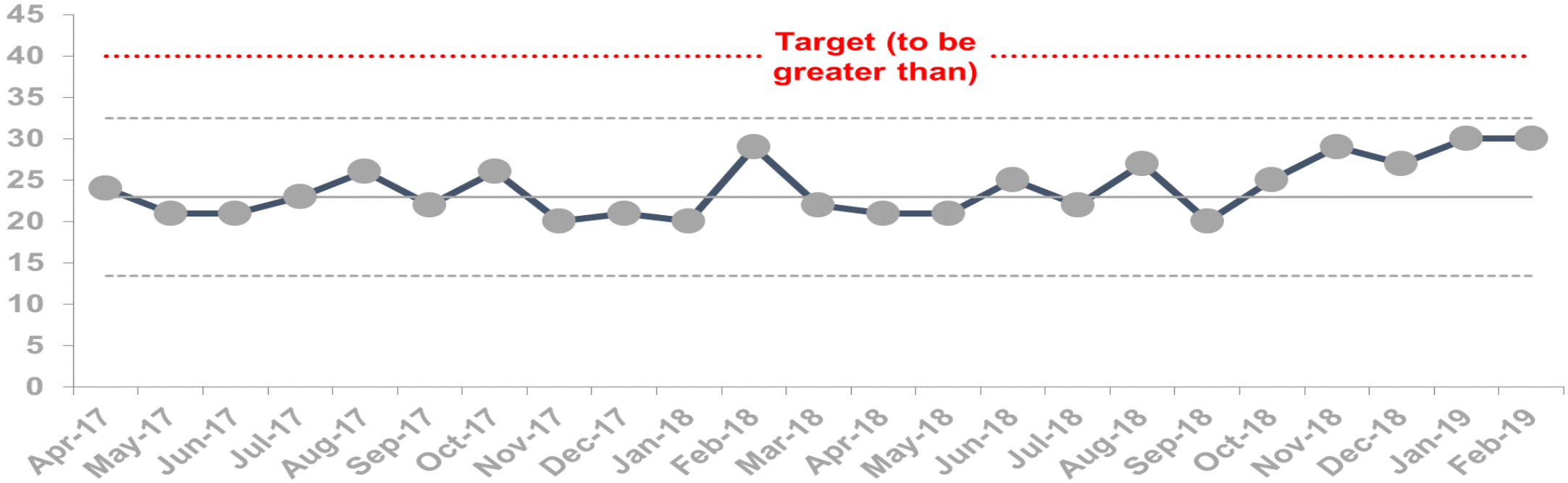




If there is ‘special cause’…..

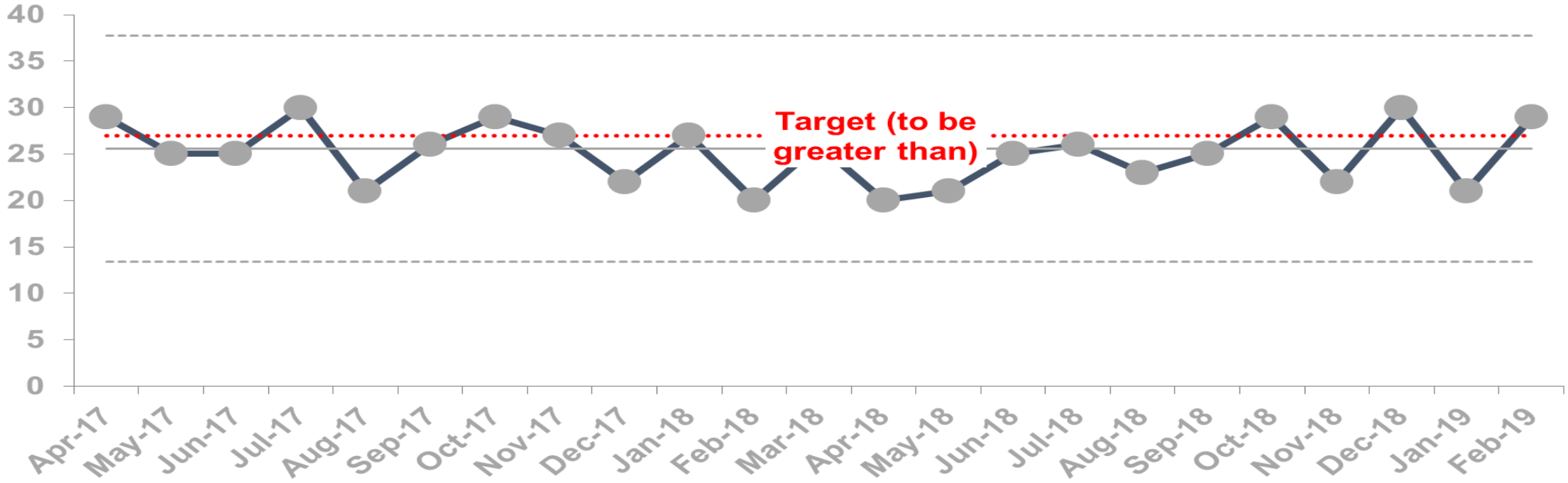


No rules triggered = common cause



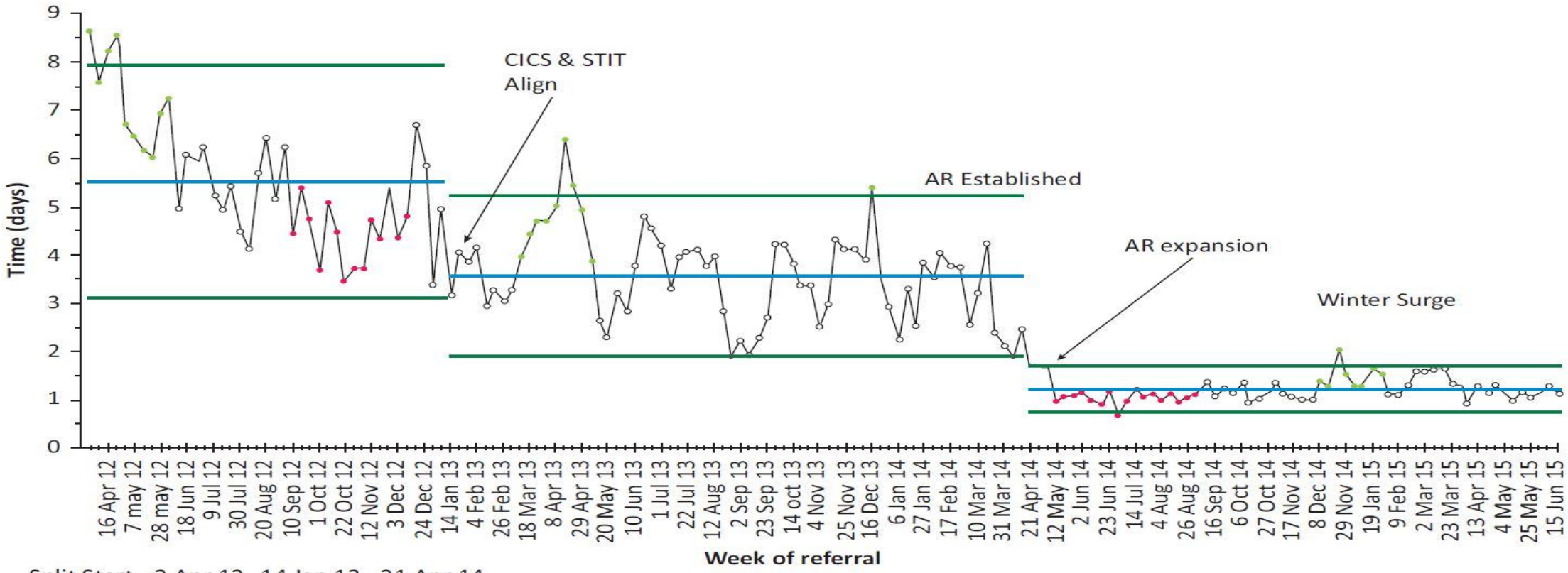
Redesign the system

SPC for assurance



Will not reliably hit the target

Has the change worked?

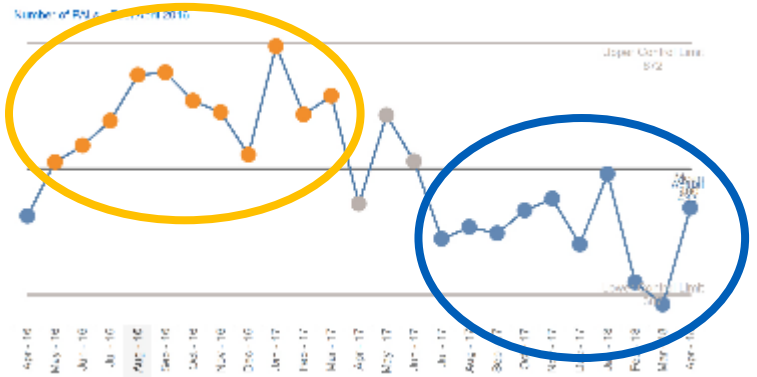


Split Start	2 Apr 12	14 Jan 13	21 Apr 14
U.C.L.	−7.9	5.2	1.7
Mean	−5.5	6.6	1.2

Fig 2. Reducing patient wait for active recovery from a hospital bed. AR = Active Recovery; CICS = Community Intermediate Care Service; STIT = Short Term Intervention Team

Maximising SPC impact

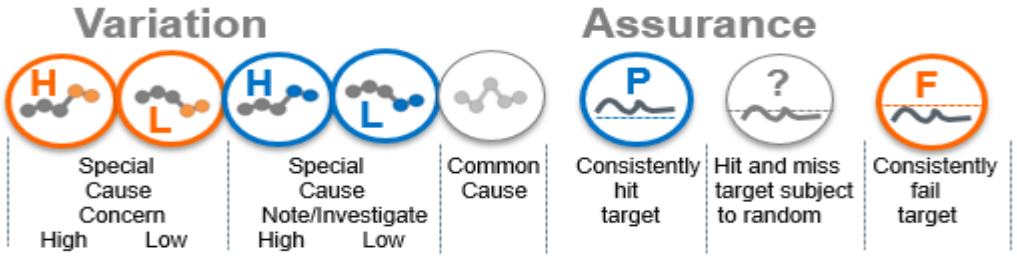
Highlight special cause



Concern

Improvement

Summary icons



Narrative which supports the data

Comment

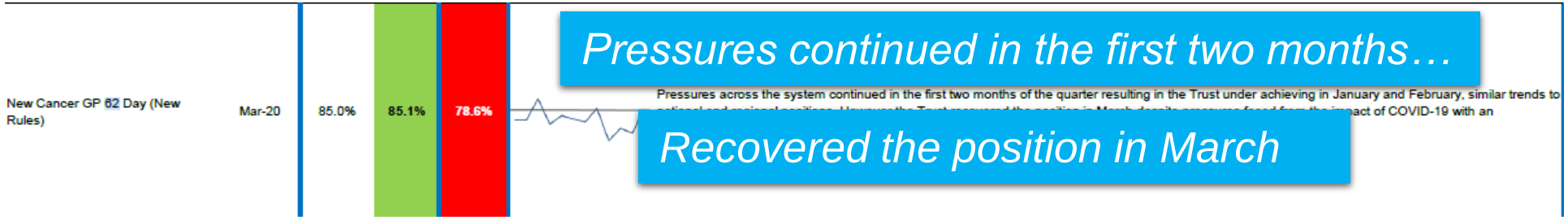
This indicator records 85% in May 2018 and is demonstrating common cause variation.

Cancer : 62-day

Integrated Performance and Compliance Dashboard - March 2020

APPENDIX 1 - SINGLE OVERSIGHT FRAMEWORK

Measure	KPI	Period	Apr-19	May-19	Jun-19	Q1	Jul-19	Aug-19	Sep-19	Q2	Oct-19	Nov-19	Dec-19	Q3	Jan-20	Feb-20	Mar-20	Q4
	Target		85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
	New Cancer GP 62 Day (New Rules)	Mar-20	80.1%	80.2%	90.3%	83.3%	78.1%	82.4%	80.7%	80.1%	79.2%	85.8%	70.2%	78.4%	76.1%	73.9%	85.1%	78.6%



Pressures continued in the first two months…

Pressures across the system continued in the first two months of the quarter resulting in the Trust under achieving in January and February, similar trends to

Recovered the position in March

Pressures have continued….

Pressures have continued in Q2 across most of the pathways which has unfortunately impacted upon the cancer 62 day standard. Despite a good recovery in 78.1%) with August showing improvement reporting at 82.4%.

A good recovery in June…

Sustainment was difficult in July…

August showing improvement

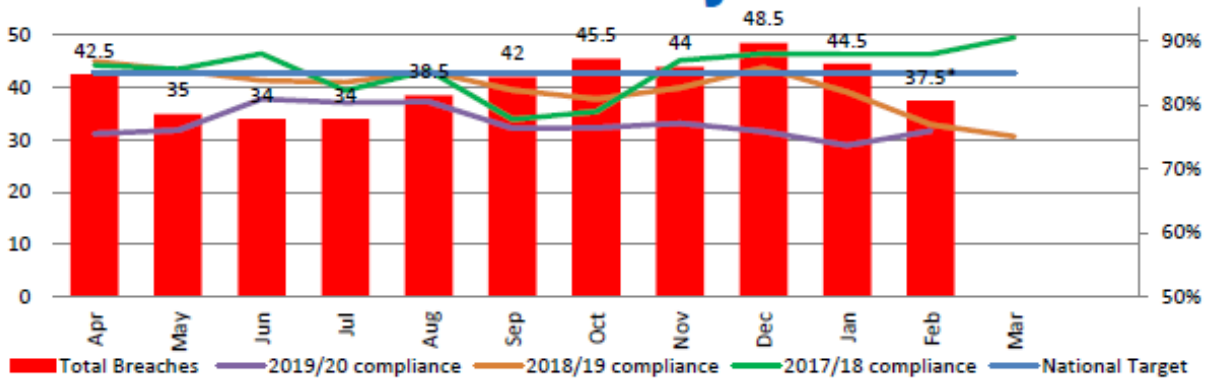
SPC chart

Common cause variation – nothing is changing

The target will be hit & missed randomly

Cancer 62 day

Performance – 62 Day Cancer Standard



% compliance and number of breaches

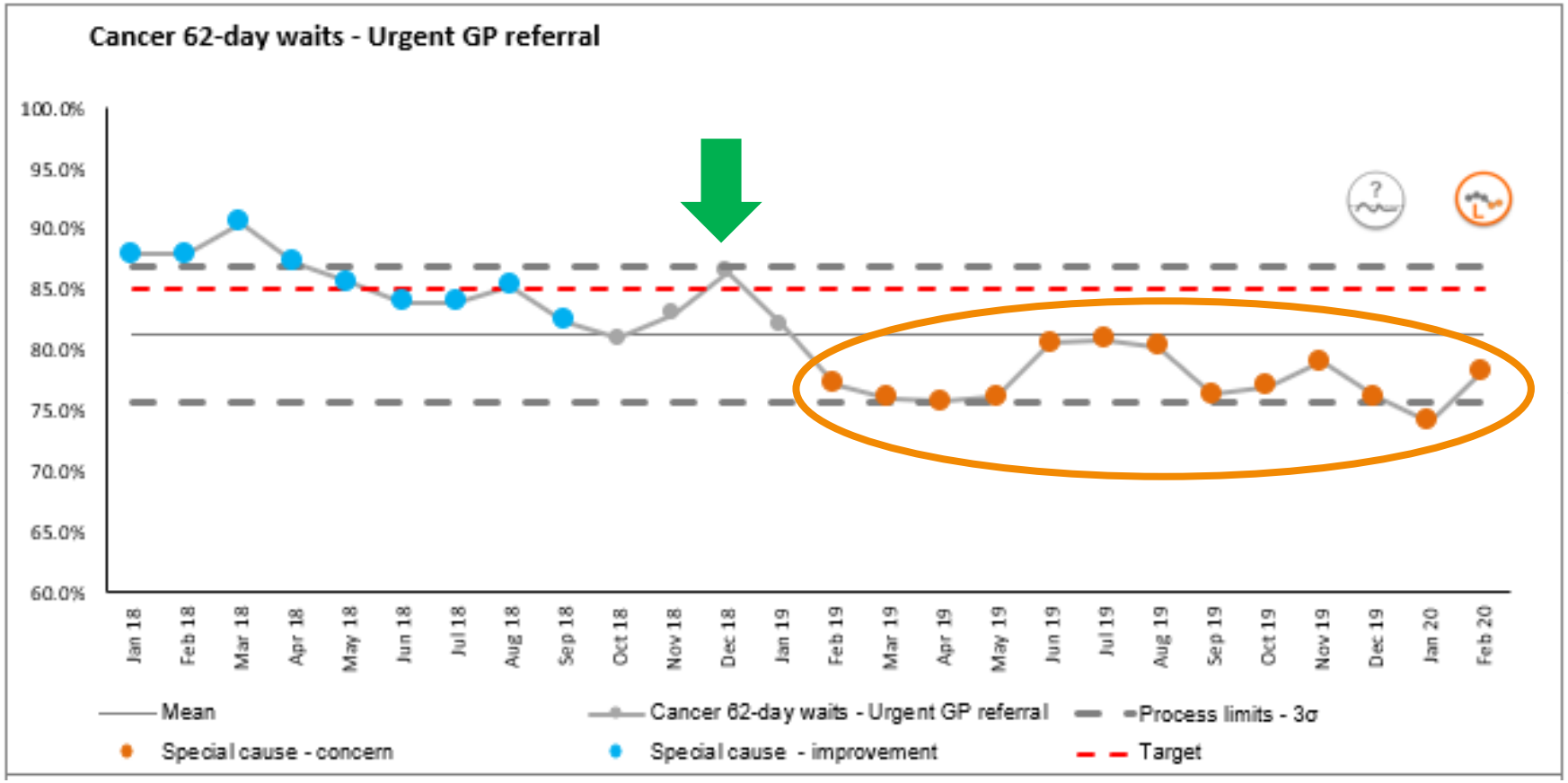
* Indicative

Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20*
80.41%	76.34%	76.42%	79.43%	75.87%	73.67%	75.97%*

Regional

Ms Re *A further decline from last month* and members noted that the Cancer 62 day target was at 72.4% which was a further decline from last month. *Doubled the amount of cancer treatments in year* the Trust has doubled the amount of treatments for cancer in *In December the Trust completed the most amount of treatments* ount of treatments. Mrs Rutter asked when the Trust will get back on track with this target. Ms Reilly disc *A recovery plan has been drafted*

Cancer 62 day



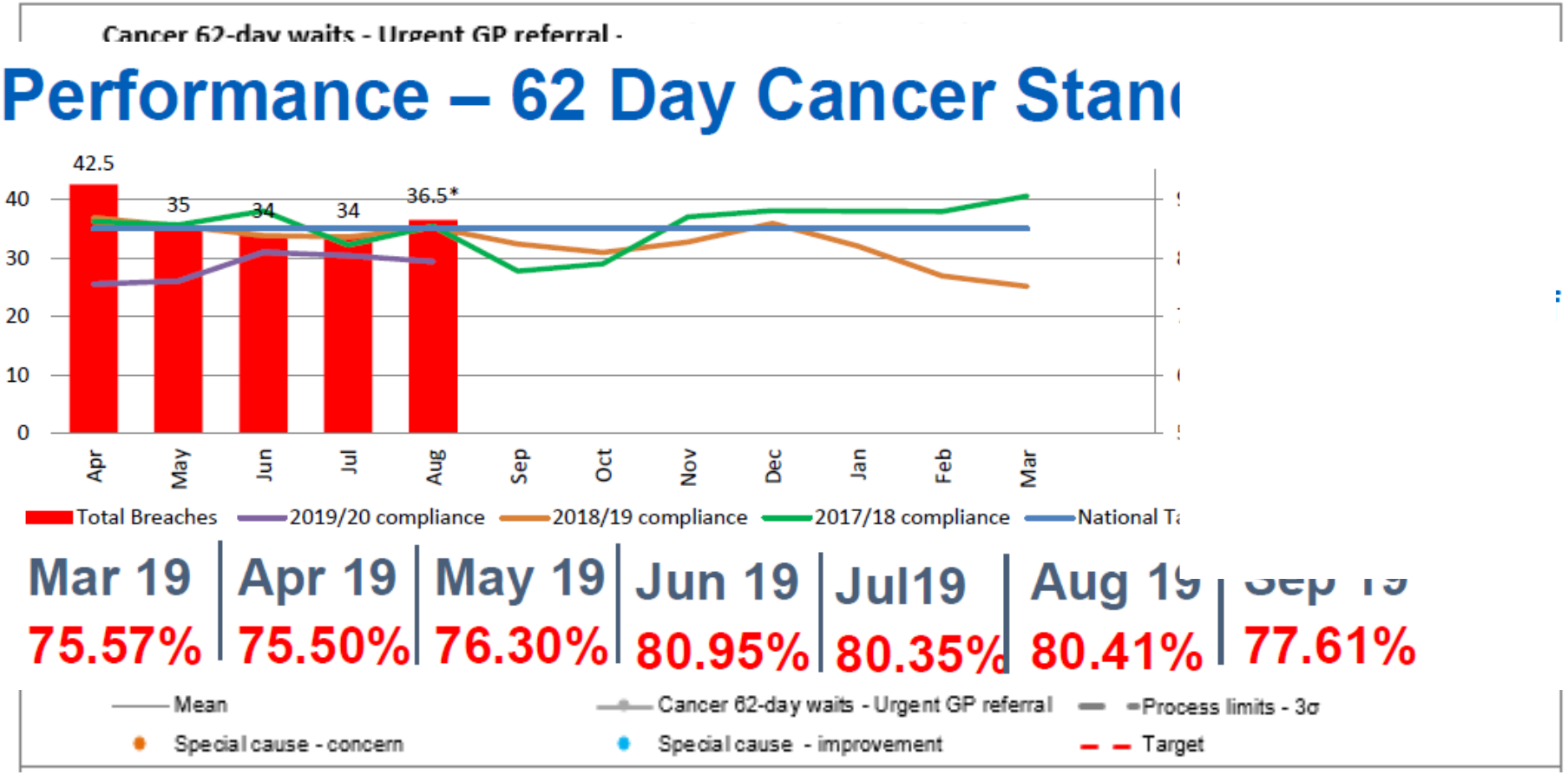
Target

13 months of concerning performance

It is unlikely that the target will be achieved

Target last achieved in December 2018

What would you like to be noticed?

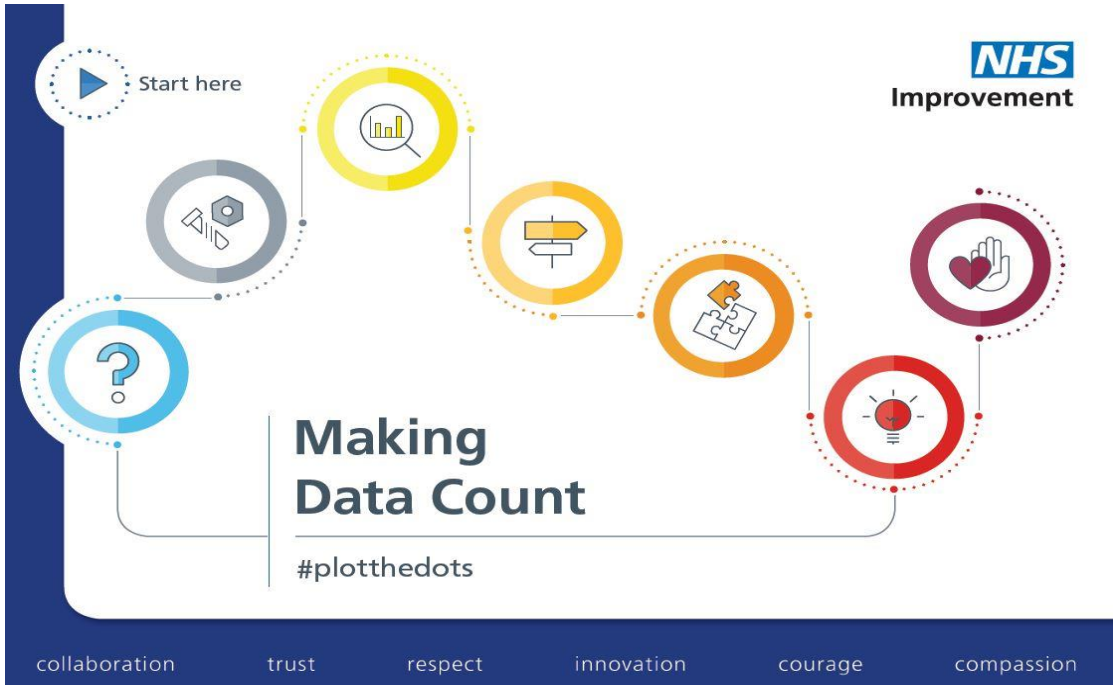


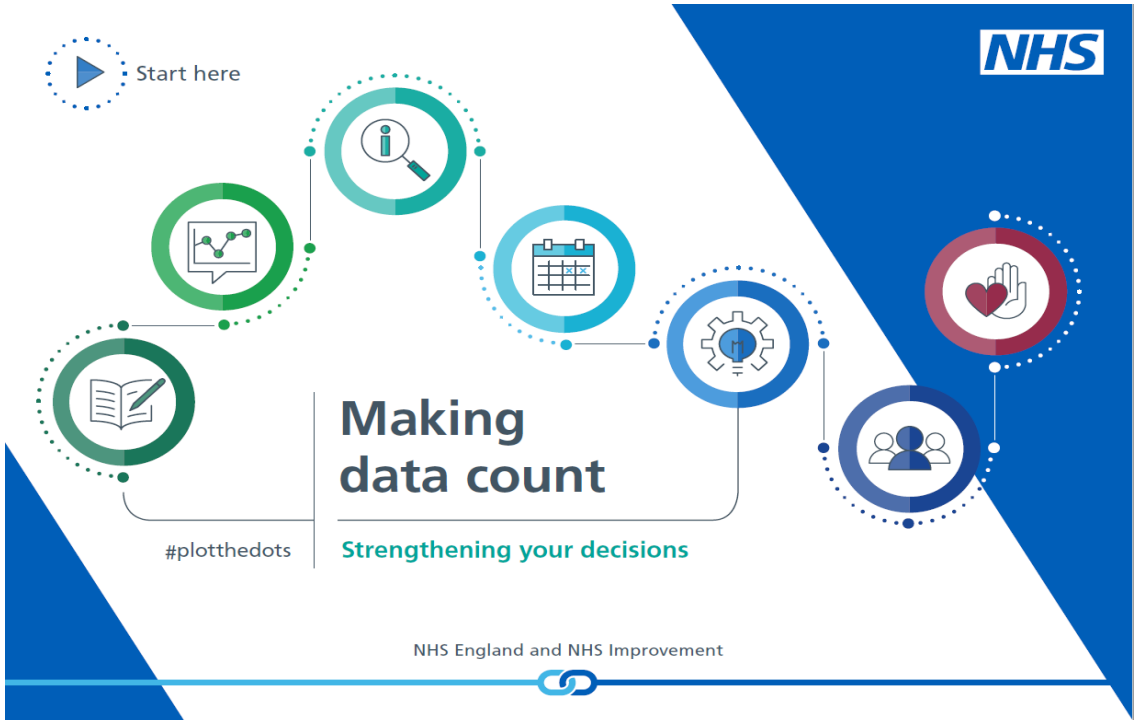
Improvement in 62 day performance

s ussed
that the Trust has seen an improvement in performance on 62
day and
year.

Optimistic to deliver this by the end of the year

Making Data Count web page





[NHS England » Making data count]

SPC Tool

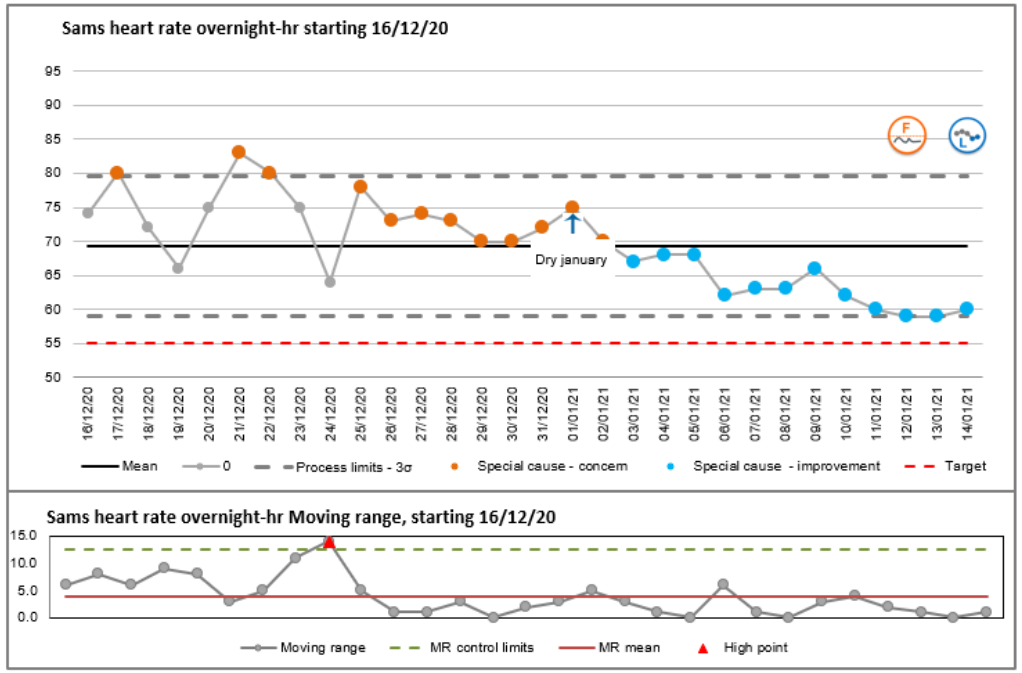
Statistical Process Control (XmR) tool

Chart title	Sams heart rate overnight
Team/unit name	hr
Your measure	
What does improvement look like?	Low is good

Target: 55.0
Maximum number: 100.0
Start date: 16/12/20
Planned duration: 100 Days
(days, weeks, months)
Include weekends? Yes
Set baseline: Days
(choose baseline period 12 - 20*)

Export chart to power point

Date	0	Date	0	Date	0	Date	0
Wed 16 Dec	74.0	Wed 13 Jan	59.0	Wed 10 Feb		Wed 10 Mar	
Thu 17 Dec	80.0	Thu 14 Jan	60.0	Thu 11 Feb		Thu 11 Mar	
Fri 18 Dec	72.0	Fri 15 Jan		Fri 12 Feb		Fri 12 Mar	
Sat 19 Dec	66.0	Sat 16 Jan		Sat 13 Feb		Sat 13 Mar	
Sun 20 Dec	75.0	Sun 17 Jan		Sun 14 Feb		Sun 14 Mar	
Mon 21 Dec	83.0	Mon 18 Jan		Mon 15 Feb		Mon 15 Mar	
Tue 22 Dec	80.0	Tue 19 Jan		Tue 16 Feb		Tue 16 Mar	
Wed 23 Dec	75.0	Wed 20 Jan		Wed 17 Feb		Wed 17 Mar	
Thu 24 Dec	64.0	Thu 21 Jan		Thu 18 Feb		Thu 18 Mar	
Fri 25 Dec	78.0	Fri 22 Jan		Fri 19 Feb		Fri 19 Mar	
Sat 26 Dec	73.0	Sat 23 Jan		Sat 20 Feb		Sat 20 Mar	
Sun 27 Dec	74.0	Sun 24 Jan		Sun 21 Feb		Sun 21 Mar	
Mon 28 Dec	73.0	Mon 25 Jan		Mon 22 Feb		Mon 22 Mar	
Tue 29 Dec	70.0	Tue 26 Jan		Tue 23 Feb		Tue 23 Mar	
Wed 30 Dec	70.0	Wed 27 Jan		Wed 24 Feb		Wed 24 Mar	
Thu 31 Dec	72.0	Thu 28 Jan		Thu 25 Feb		Thu 25 Mar	
Fri 01 Jan	75.0	Fri 29 Jan		Fri 26 Feb			
Sat 02 Jan	70.0	Sat 30 Jan		Sat 27 Feb			
Sun 03 Jan	67.0	Sun 31 Jan		Sun 28 Feb			
Mon 04 Jan	68.0	Mon 01 Feb		Mon 01 Mar			
Tue 05 Jan	68.0	Tue 02 Feb		Tue 02 Mar			
Wed 06 Jan	62.0	Wed 03 Feb		Wed 03 Mar			
Thu 07 Jan	63.0	Thu 04 Feb		Thu 04 Mar			
Fri 08 Jan	63.0	Fri 05 Feb		Fri 05 Mar			
Sat 09 Jan	66.0	Sat 06 Feb		Sat 06 Mar			
Sun 10 Jan	62.0	Sun 07 Feb		Sun 07 Mar			
Mon 11 Jan	60.0	Mon 08 Feb		Mon 08 Mar			
Tue 12 Jan	59.0	Tue 09 Feb		Tue 09 Mar			



Instruction sheet | Clear data
Print | Save | Clear interventions

Set vertical axis: Change axis
* see instruction sheet point 9

min value	50.0
max value	95.0
number format	Integer
date format	dd/mm/yy

Interventions annotation date
enter a date and select comment

01/01/2021	Dry january
04/01/2021	
04/01/2021	
31/12/2020	
02/01/2021	

Recalculating the process limits
enter a date and select comment

02/01/2021	

Summary statistics **Data observations**

[NHS England » Statistical process control tool]

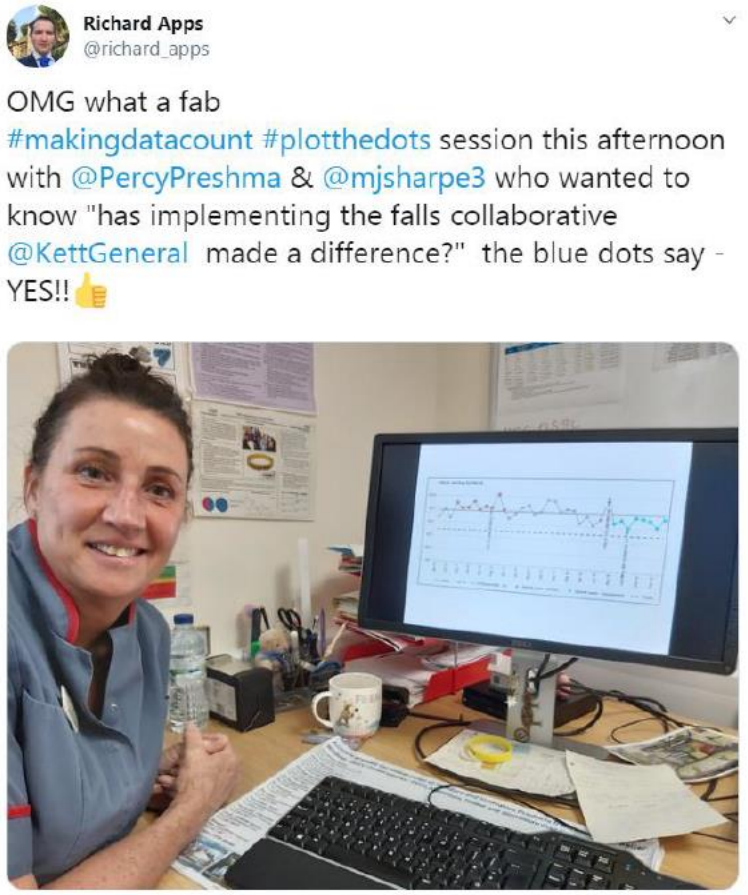
Local action

Has the falls collaborative made a difference?

Rie Sharp from the Practice Development team has been leading the Trust's work on reducing harm from patient falls; although a lot has been done, there is no explicit evidence that a change has occurred, or if that change is an improvement.
Rie had one question –

"Has implementing the falls collaborative made a difference?"

Using the SPC tool gave the almost instantaneous answer - YES – a statistically significant reduction in reported patient fall incidents can be seen directly after the introduction of the falls collaborative – and it has sustained…!



Virtual teams training

STEP 1	Intro to Making Data Count	9 April 11.30-12.30
STEP 2	Using our SPC tools	20 April 10.00-11.00
STEP 3	Writing narrative	27 April 14.00-15.00
STEP 4	Tips to convert your colleagues	6 May 12.00-13.00
STEP 5	Comparisons and benchmarking	12 May 14.00-15.00

Staying connected

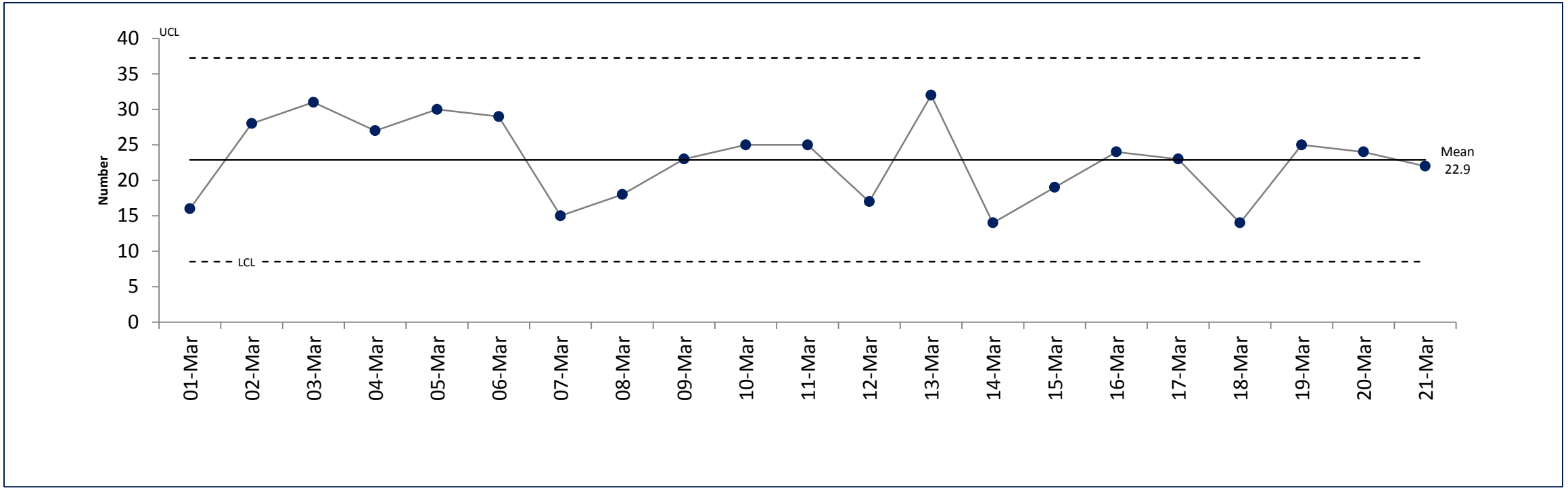
https://future.nhs.uk/MDC/grouphome

Making Data Count Ireland

Dr Jennifer Martin
Evidence for Improvement Lead

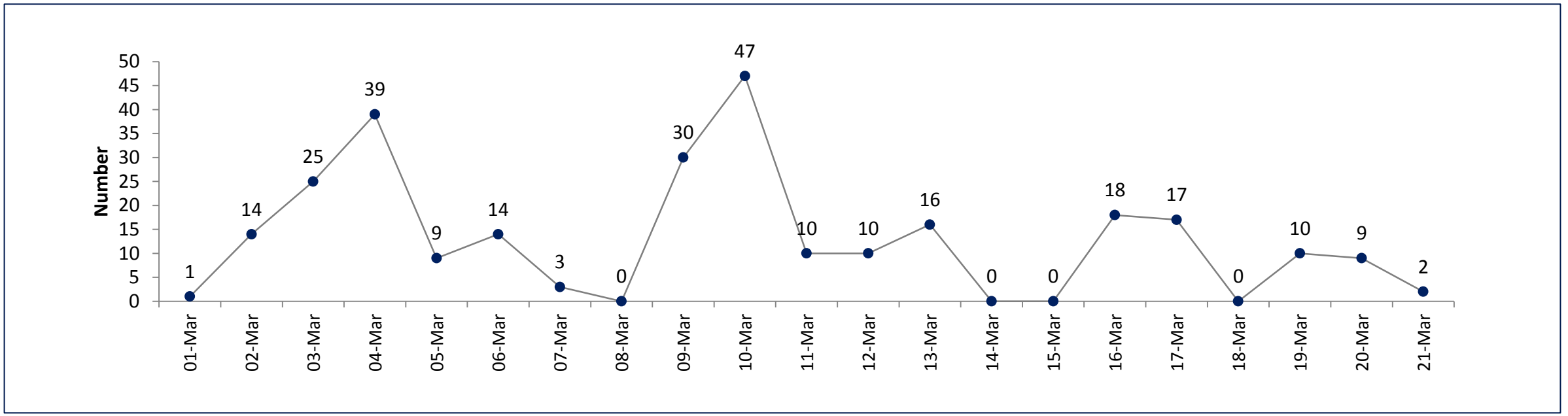
Evidence for Improvement Team
Gráinne Cosgrove
Dr. Gemma Moore
Emma Hogan
Nicola O'Grady
Zuneera Khurshid

COVID-19 Data summary



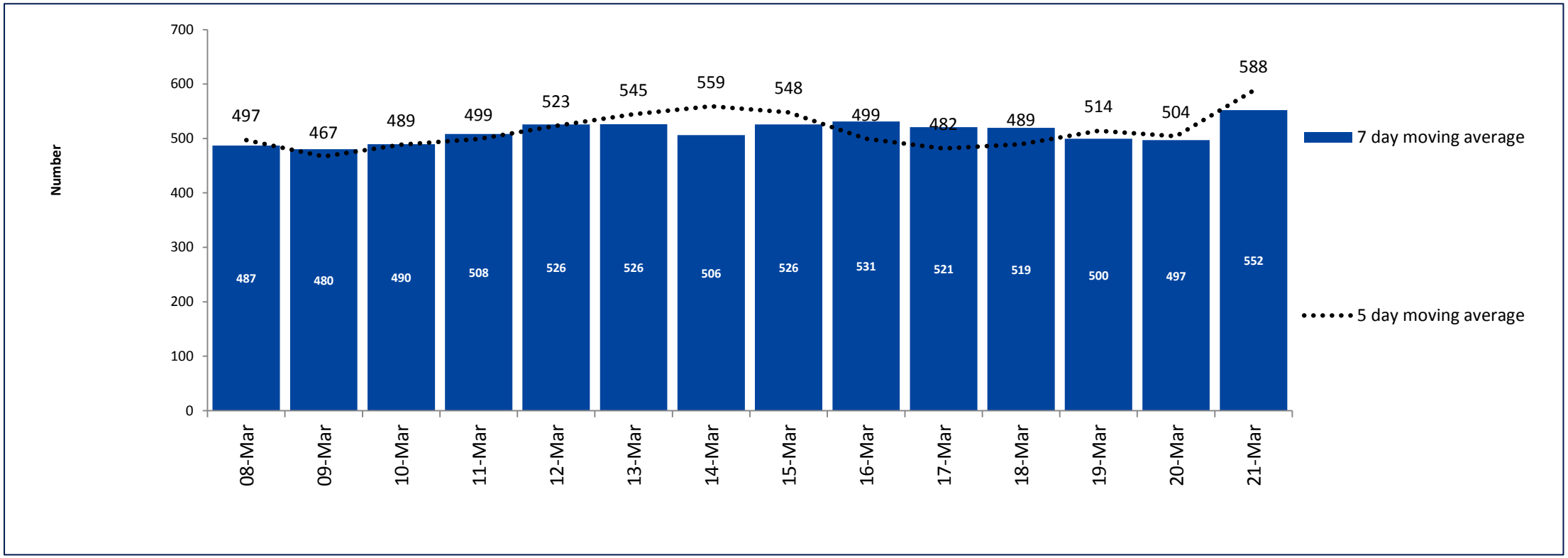
Number of hospital admissions during the previous 24 hours of COVID positive patients is stable. Admissions this week are down 2% compared to last week. 22 new admissions today, with 10 discharges.

COVID-19 Data summary



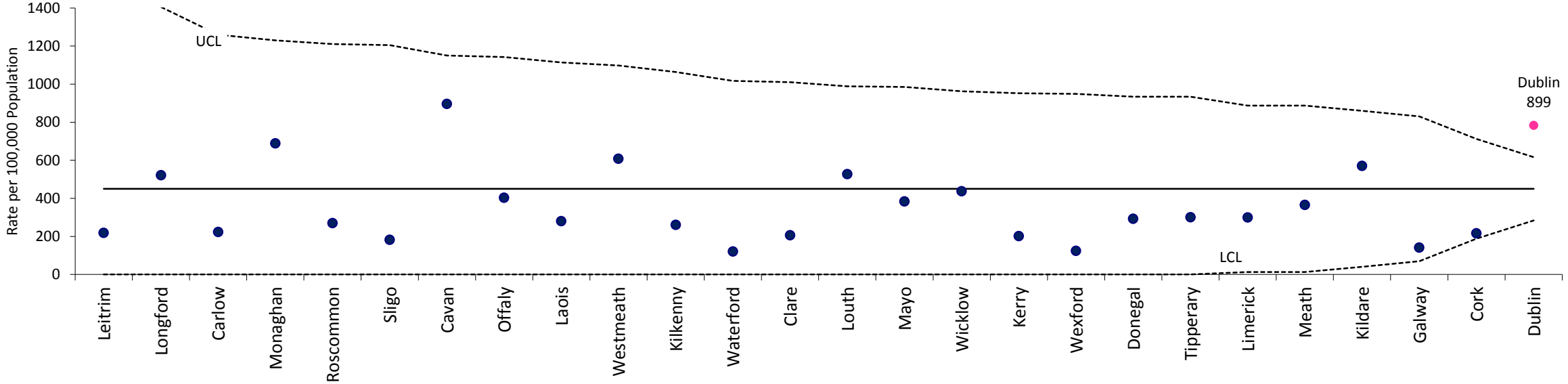
Number of deaths among people with confirmed, probable or possible COVID notified by day. To date, there have been 4,587 deaths among people with confirmed, probable or possible COVID notified.

COVID-19 Data summary



The 5- and 7-day moving averages of new cases per day fluctuate by day and are slightly increased from last week. Compared to last week, the 5-day average is up 5% and the 7-day average is up 9%.

Surveillance report: Covid-19 funnel plot (June 2020)*



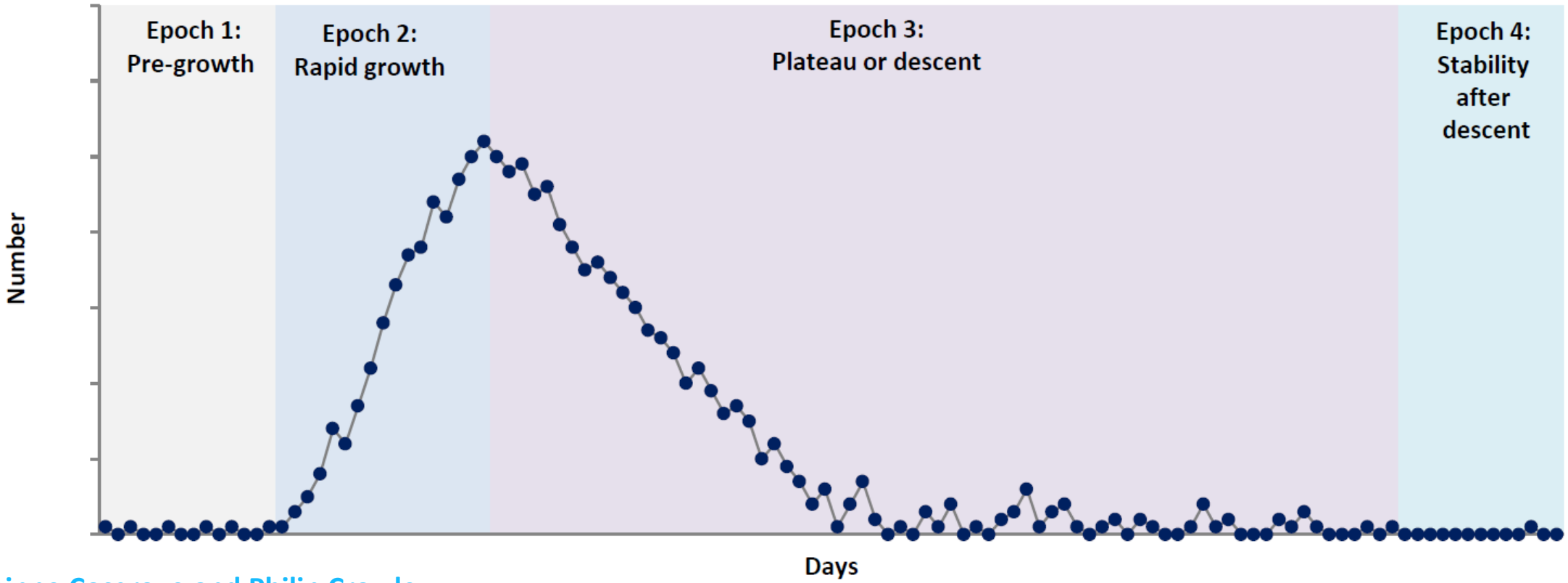
Funnel Plot presenting the Rate of COVID-19 cases per 100,000 population by county:

- "One of our counties was highest rate in the country on several occasions and we would get queries from HPSC, DOH as well as local politicians and we used the funnel plot to show most importantly that yes, it was the highest rate in the country, but it was still within the limits and therefore this is taken into account whilst doing our overall Public Health Risk Assessment. This seemed to be a good communication tool with our regional stakeholders, including TDs"
- "Equally, there were times that one of the counties was outside the limits and then the local public health team would discuss possible explanations and explore potential interventions that could be taken or tailor the response to investigations"

***Work done by North East Department of Public Health in Navan**

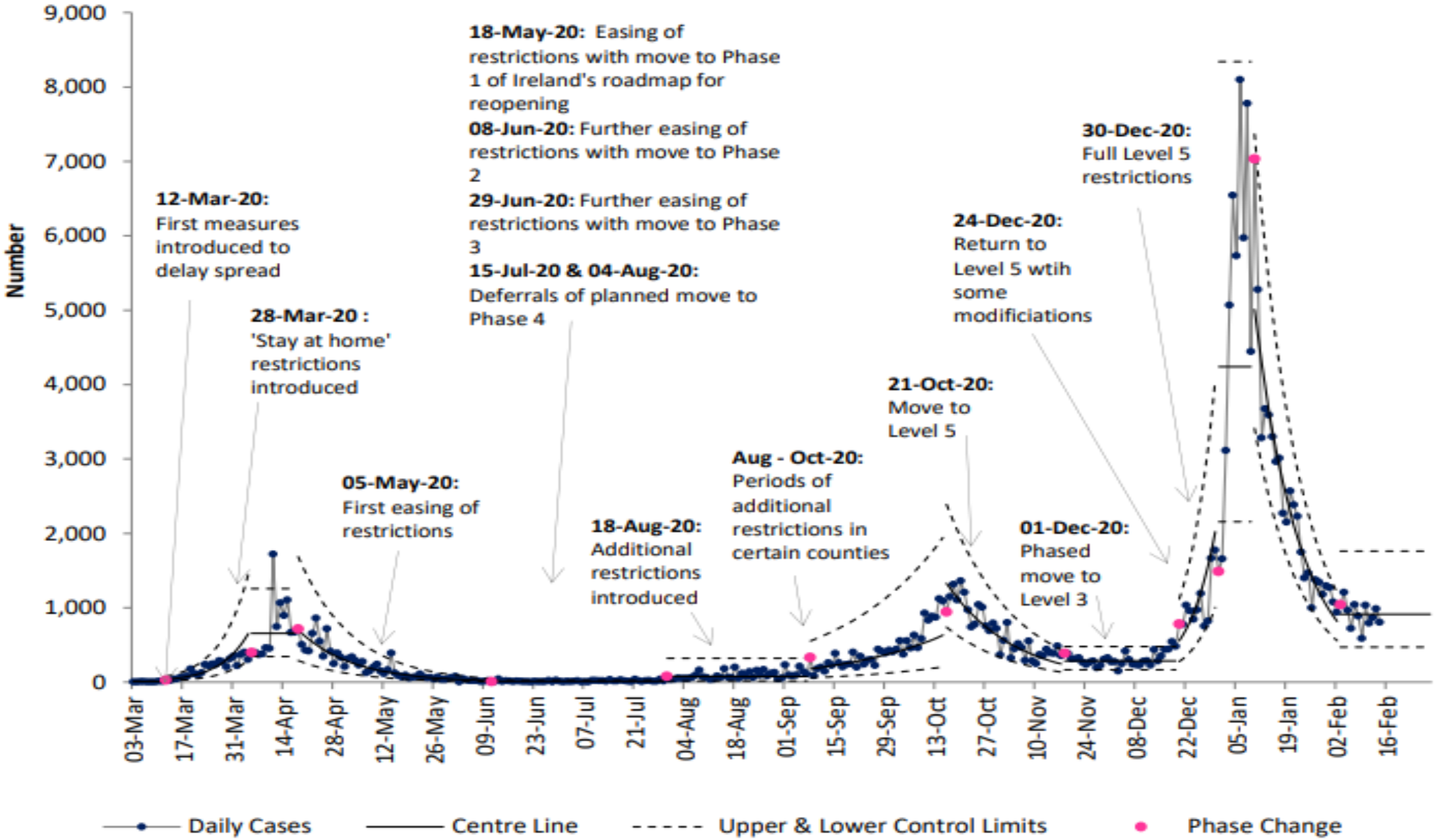
Understanding variation in key COVID-19 indicators using SPC

Figure 1: Example of the four epochs in an epidemic curve

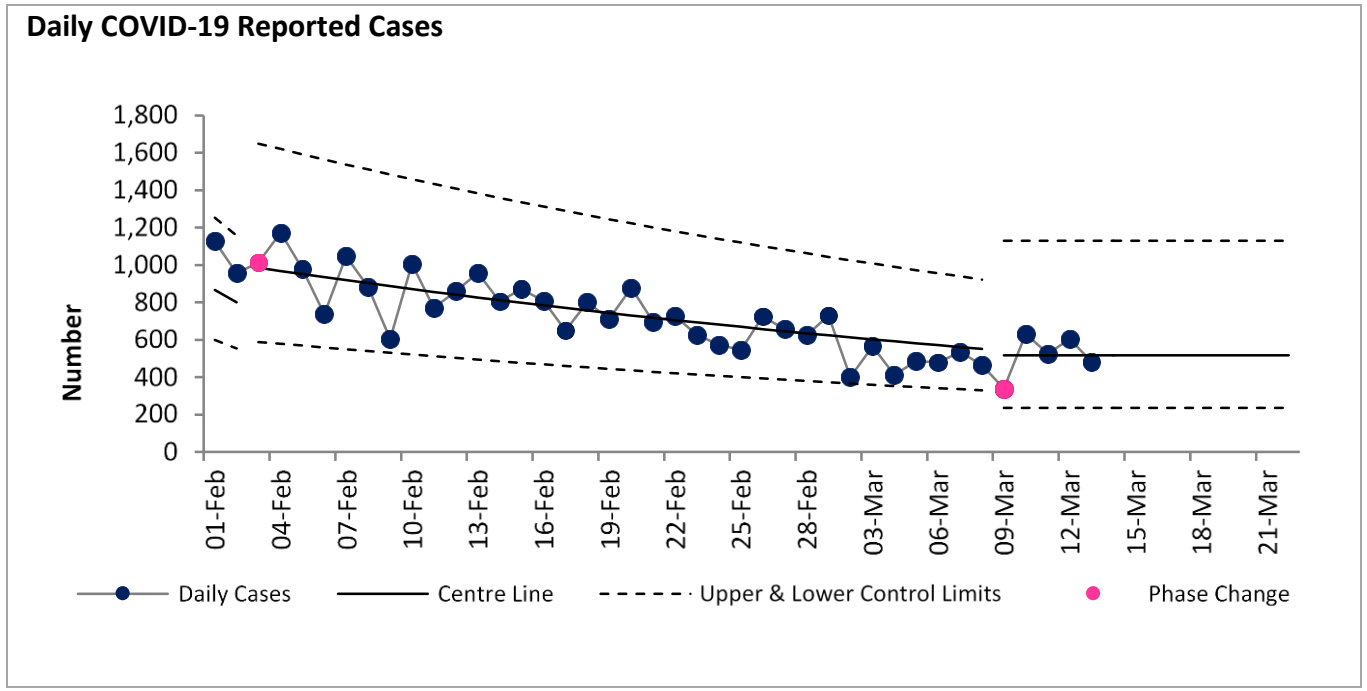


[Grainne Cosgrove and Philip Crowley]
https://www.hse.ie/eng/about/who/qid/covid-19-qi-learning/resources-developed-to-support-the-national-covid19-response/understanding-variation-in-key-covid-19-indicators-in-ireland-using-statistical-process-control-shewhart-charts.pdf

Statistical process control chart of daily reported cases in Ireland



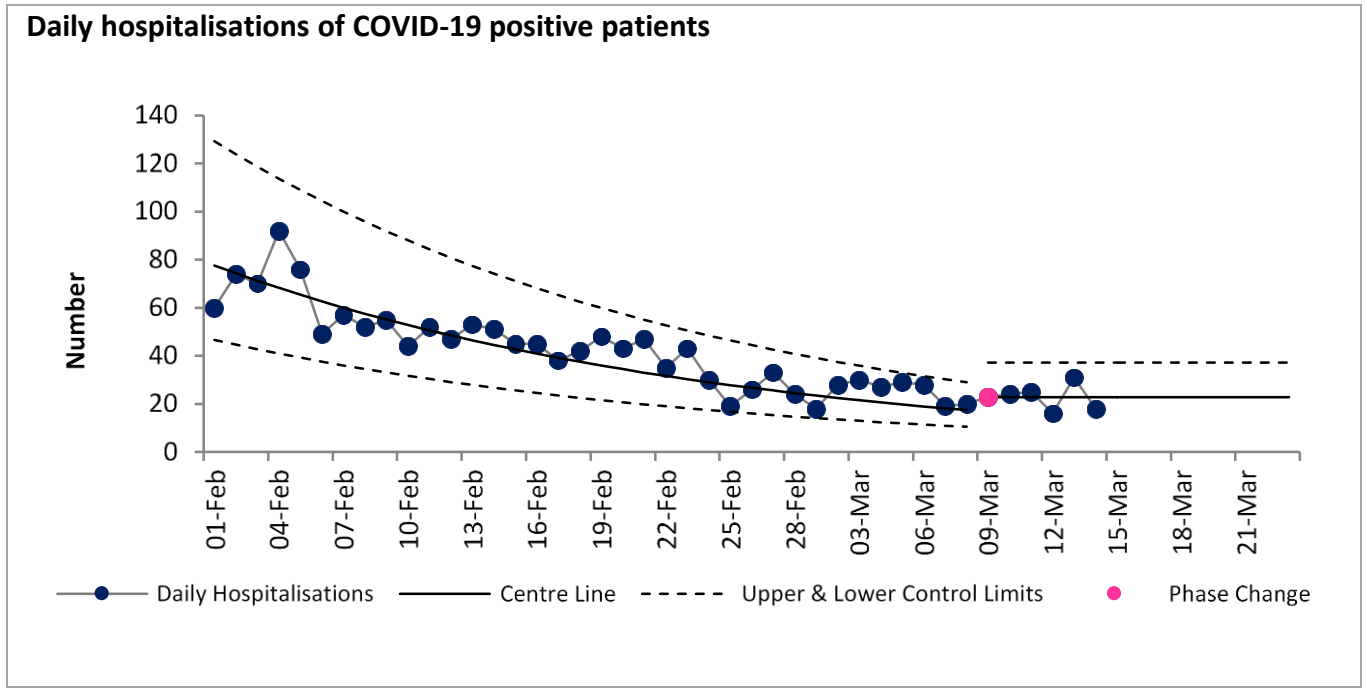
COVID-19 SPC report



Epoch 3: Plateau or descent in daily reported cases

The number of cases has been decreasing since 10th January. Between 3rd February & 8th March cases continued to trend downwards but at a slower rate. During this time the average decreased from 985 to 551 per day. Since 9th March the number of cases has stabilised, and based on the current data we can continue to expect to see an average of 516 new cases per day.

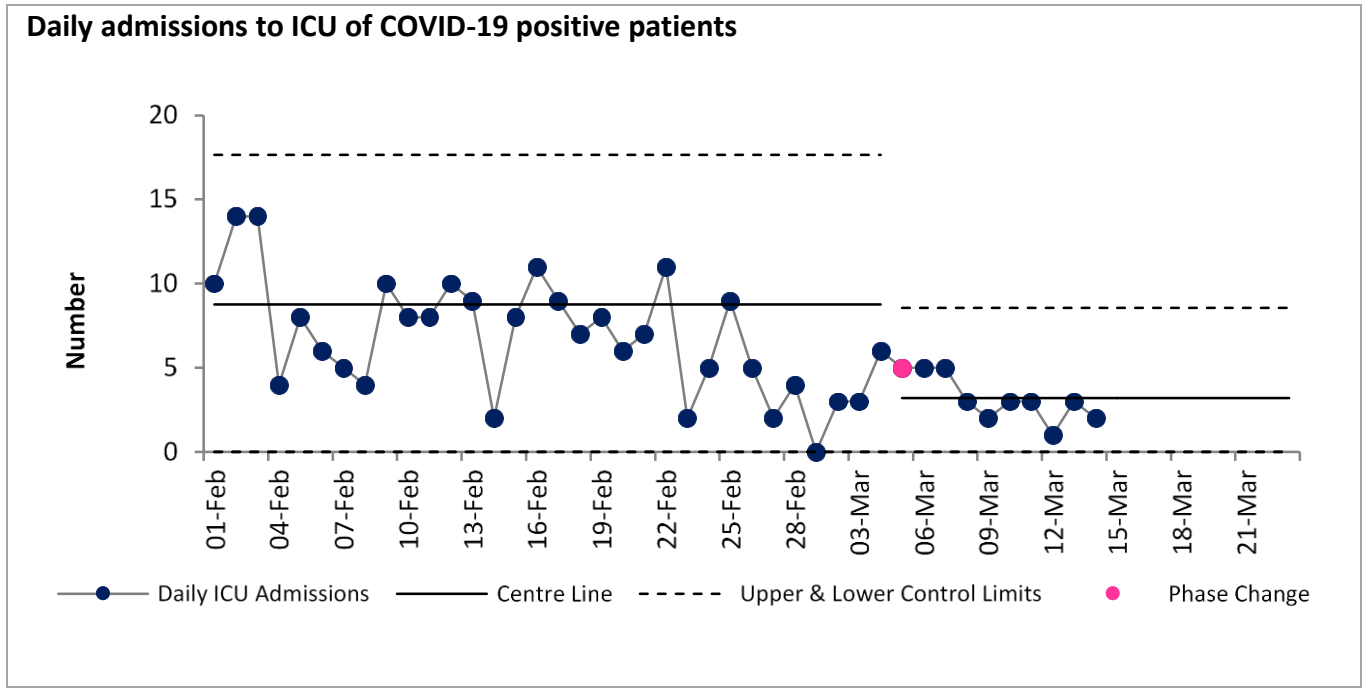
COVID-19 SPC report



Epoch 3: Plateau or descent in daily reported hospitalisations (new admissions on the day)

The number of hospitalisations per day trended downwards from 1st Feb to 8th March, during which time the average decreased from 78 to 17 per day. However there was a signal of change on 9th March which indicates that the number of hospitalisations is now stabilising. Based on the current data we can expect an average of 23 hospitalisations per day.

COVID-19 SPC report



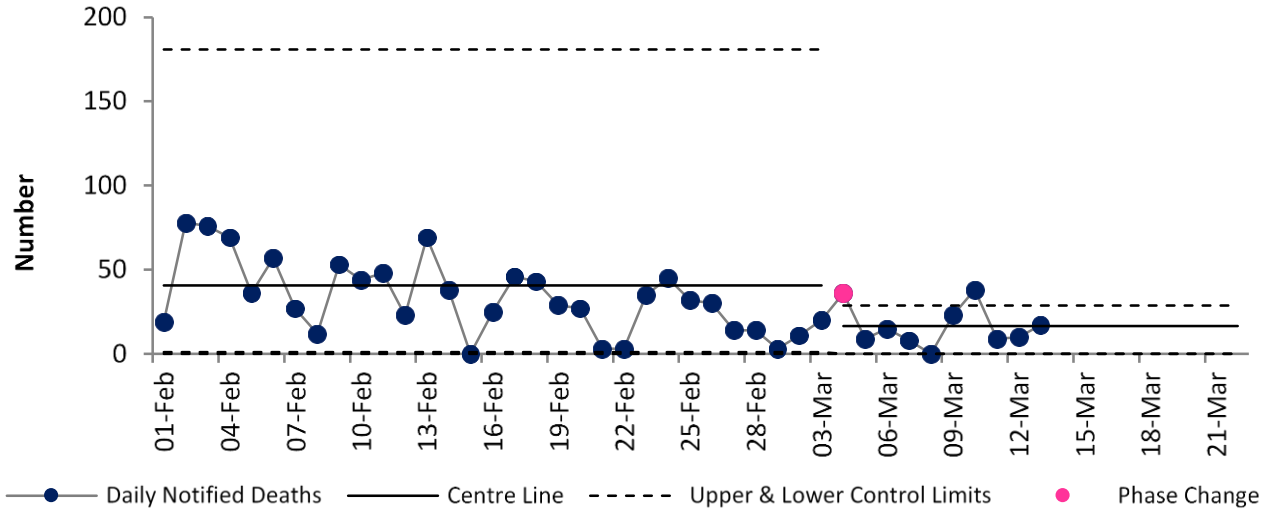
Epoch 4*: Stability after descent in daily reported ICU admissions

There was a signal of a reduction in the average number of ICU admissions per day from 8.8 since 1st Feb to 3.2 since 5th March. The number is stable since then, and based on the current data we can expect to continue to see an average of 3.2 admissions per day.

* Note that following the first report describing the methodology used here, the ICU data source was revised. The updated data shows a period of rapid growth from 29th Dec followed by a period of stability in January and a subsequent decline. This means that ICU admissions are now in Epoch 4.

COVID-19 SPC report

Daily notified deaths of people with confirmed, probable or possible COVID-19



Epoch 3: Plateau or descent in daily reported deaths

Between 1st February and 3rd March there was an average of 41 deaths notified per day. There was a signal of a reduction (a series of 8 days below average), and since 4th March the average has been 17 deaths per day. The number of deaths notified per day is now stable, and while it remains stable we can expect to continue to see an average of 17 deaths notified per day.

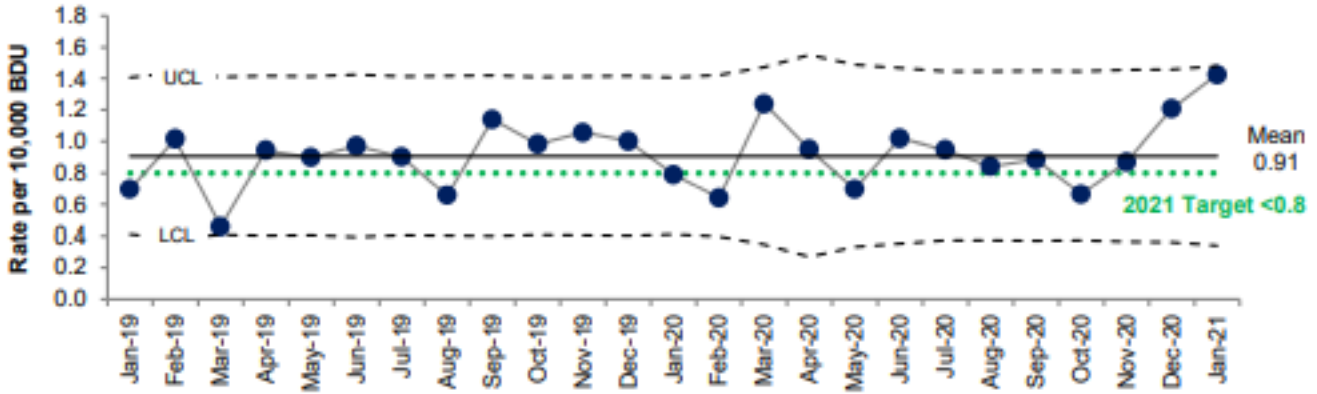
The National Quality Profile- March 2021:

Hospital acquired new cases of *S. aureus* bloodstream infection per 10,000 bed days used

Desired Direction ↓

Safe

National Rate



Average national performance is stable, but worse than the 2021 target.

There are no signals of a change in the rate of Staph Aureus per 10,000 bed days used since January 2019. While the rate for Jan-21 is above average, it is within the control limits and is not a signal of disimprovement.

NEW DATA

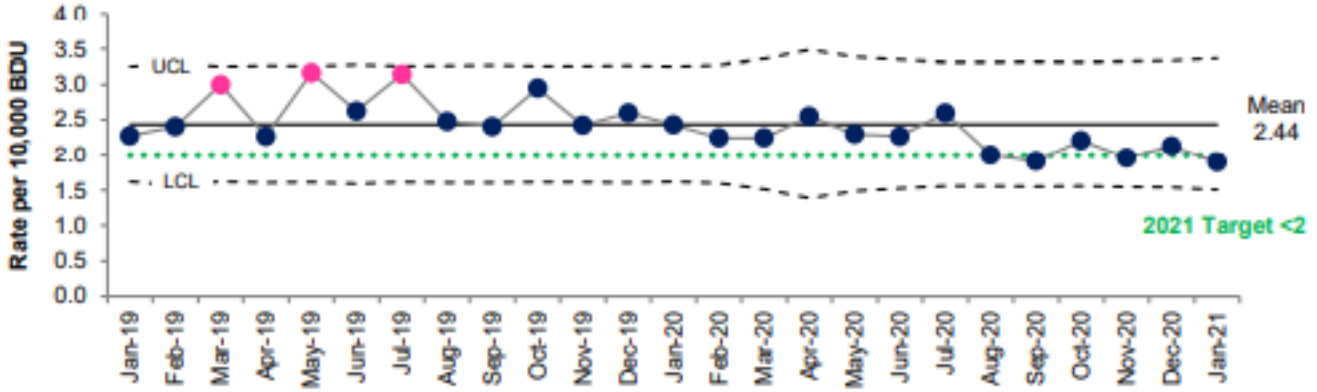
Latest data available: January 2021

Hospital acquired new cases of *C. difficile* infection per 10,000 bed days used

Desired Direction ↓

Safe

National Rate



Average national performance is worse than the target but has been stable since August 2019.

The rate of hospital acquired new cases of C. difficile per 10,000 bed days used remains stable since Aug-19. While the rates for Sept-20, Nov-20 & Jan-21 were below target, using SPC rules they were within the expected range of variation and so are not signals of improvement.

NEW DATA

Latest data available: January 2021

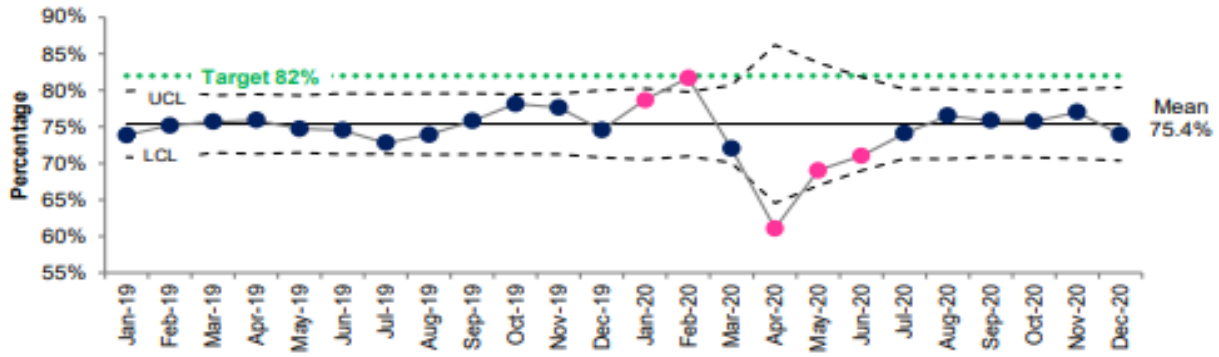
The National Quality Profile- March 2021:

Efficient

Day of surgery admission (DOSA) rate

Desired Direction ↑

National Rate



Average national performance is worse than the target but showed signals of improvement in January & February 2020. However there were signals of disimprovement between April & June 2020. Since July 2020 performance is stable but below target.

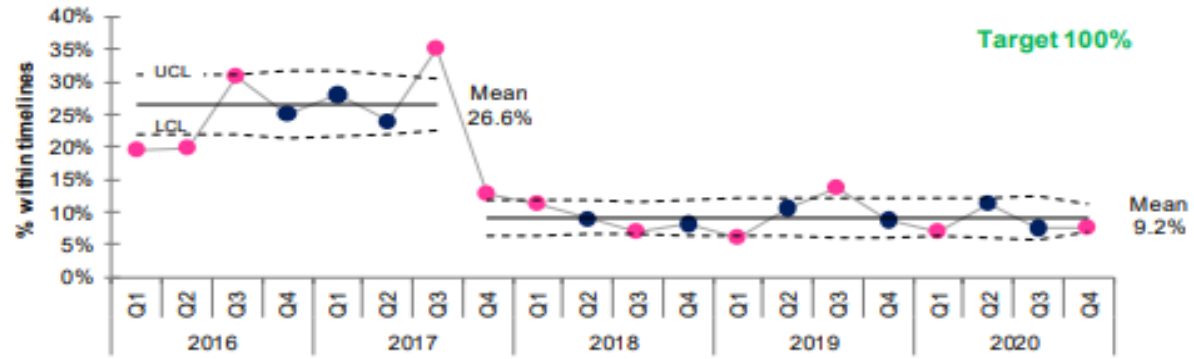
NEW DATA

Latest data available: Dec 2020

Equitable

Disability Act Compliance: percentage of child assessments of need completed within the timelines

National Rate



Average national performance is worse than the target with a sustained reduction since Q4 2017. The control limits have been recalculated to reflect this. Performance is unstable, with more variation than expected between quarters.

NO NEW DATA

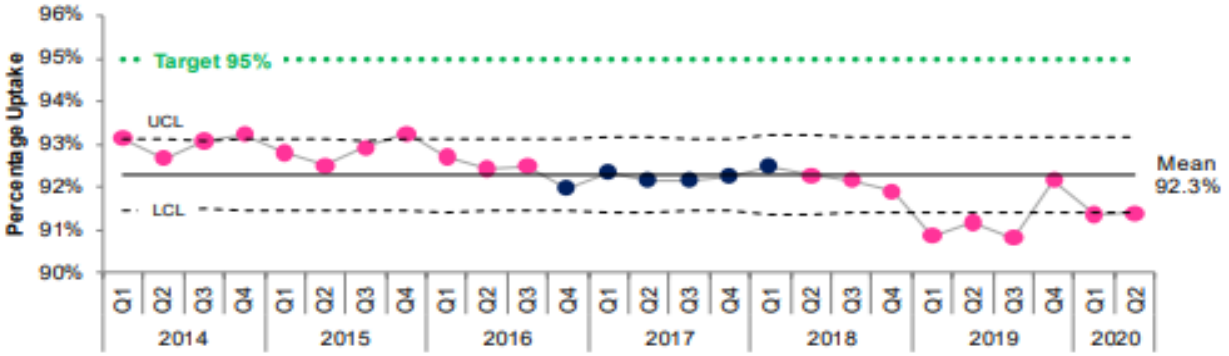
Latest data available: Q4 2020

Better Health & Wellbeing

MMR vaccination rate

Desired Direction ↑

National Rate



Average national performance is worse than the target, with a signal of a reduction between Q4 2016 and Q1 2018 relative to previous quarters, and a signal of a further sustained reduction in the uptake rate since Q2 2018.

NO NEW DATA

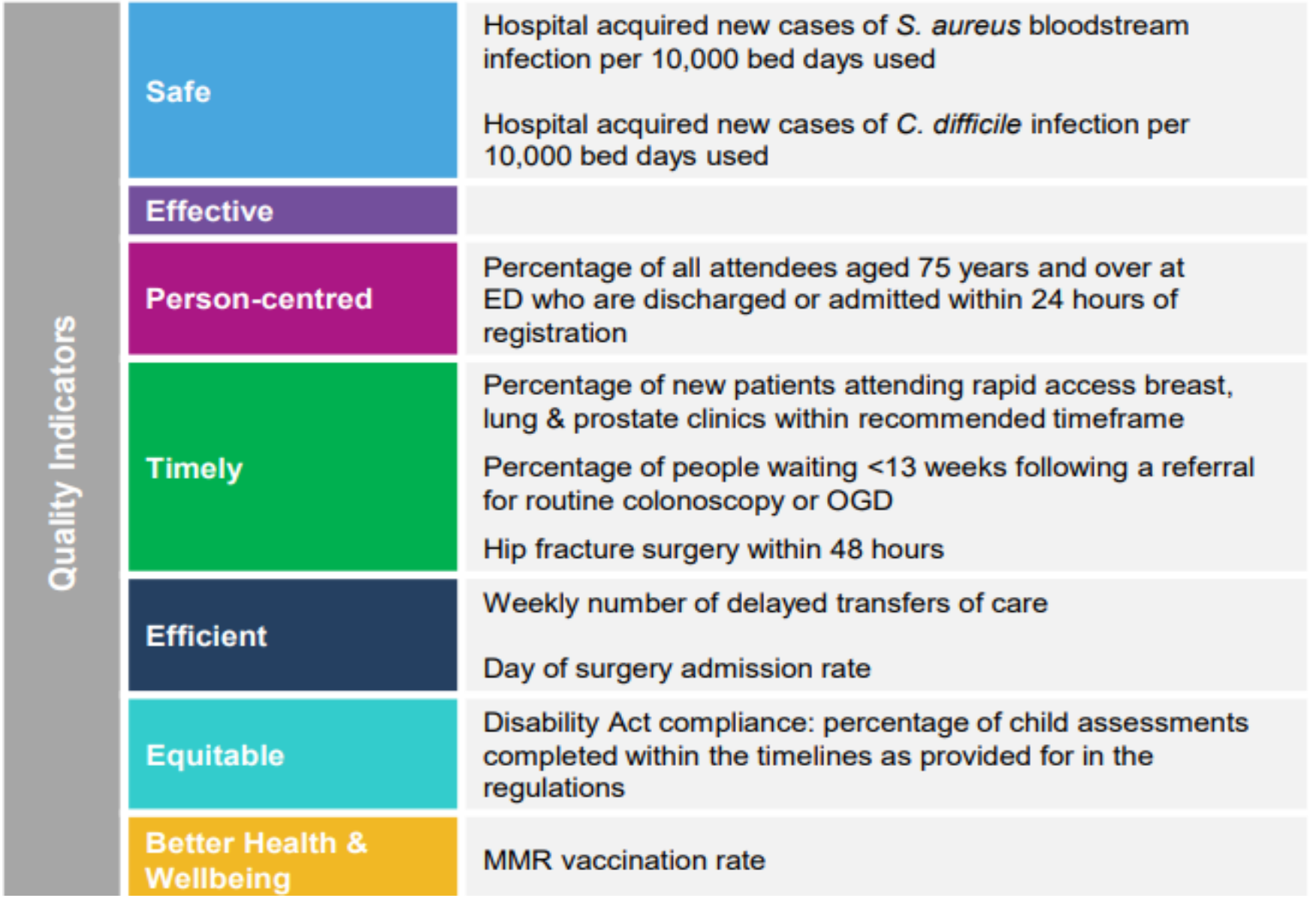
Latest data available: Q2 2020
Note: data for Q3 2020 is incomplete and therefore not presented in this version.

CHAMPION PARTNER ENAB

Building a Better Health Service | Seirbhís Sláinte Níos Fearr á Forbairt
National Quality Improvement Team

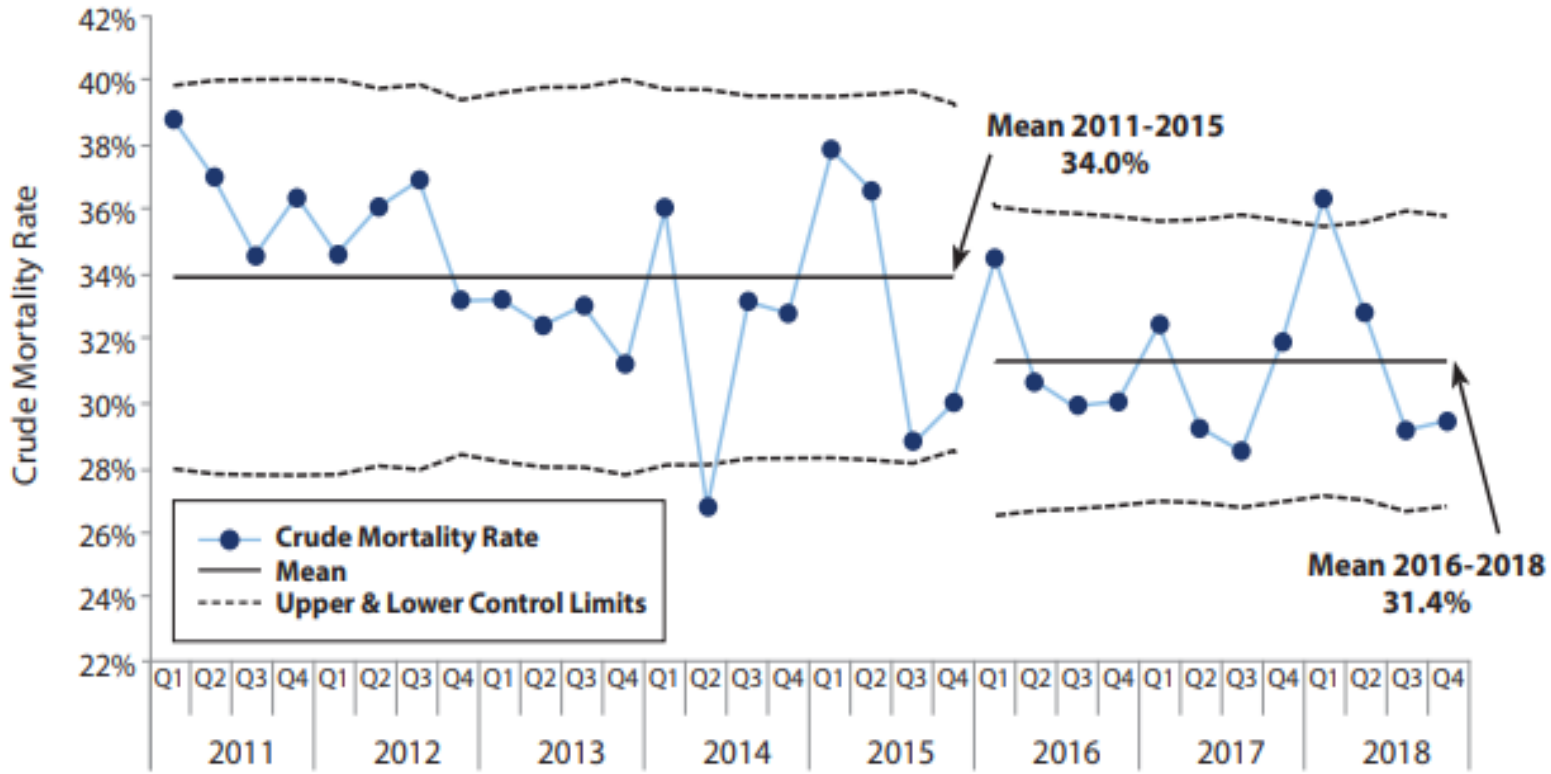
The National Quality Profile-March 2021*

*Quality Profile not produced in March, April and May due to staff redeployment during COVID-19



Irish National Sepsis Report-2018

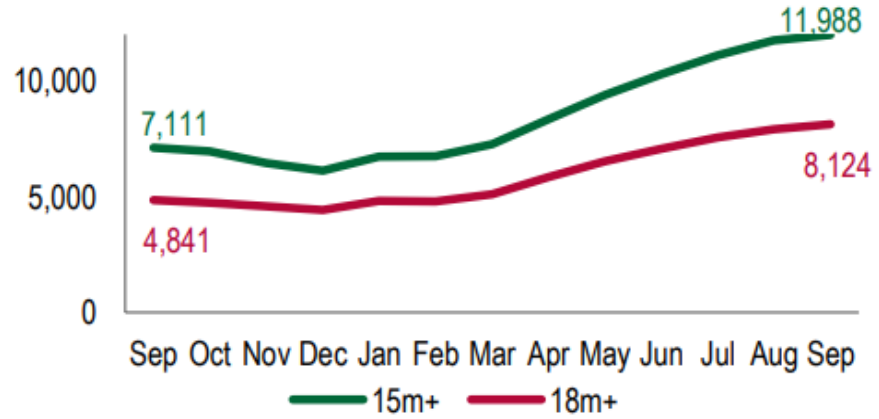
FIGURE 11: Statistical process control chart of hospital mortality for adult inpatients with a diagnosis of sepsis and admitted to a critical care area, quarterly data, 2011 – 2018.



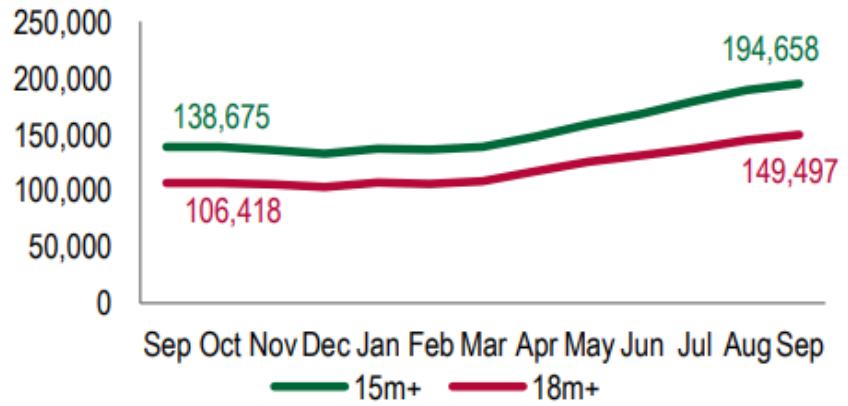
https://www.hse.ie/eng/about/who/cspd/ncps/sepsis/resources/national-sepsis-report-2018.pdf

Health Services Performance Profile July - September 2020

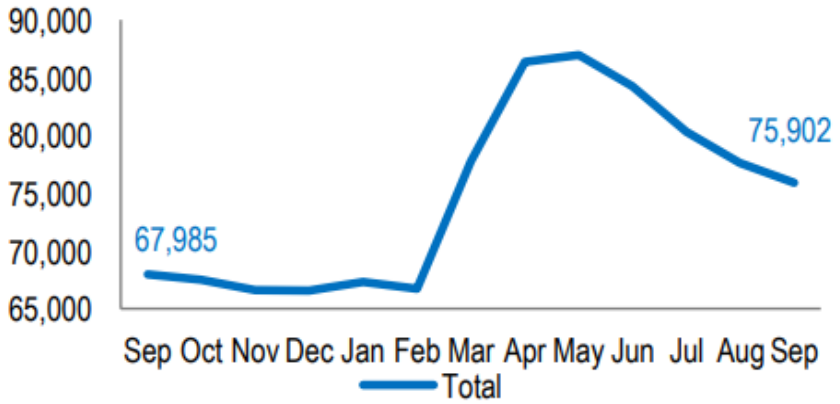
Inpatient & Day Case Waiting List



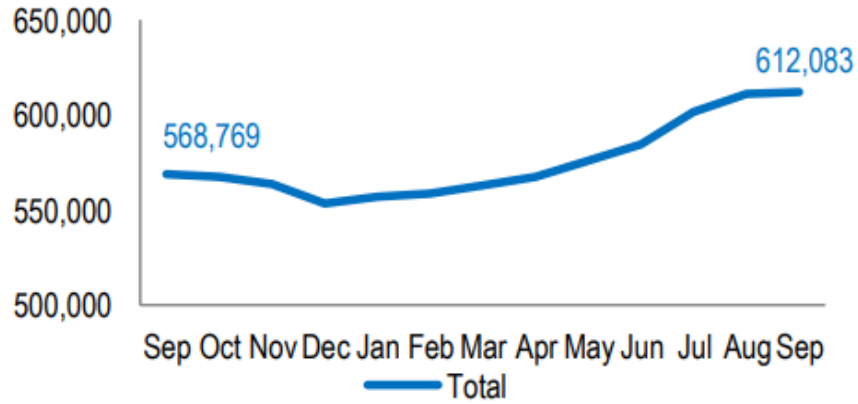
Outpatient Waiting List



Inpatient & Day Case Waiting



Outpatient Waiting List Total



https://www.hse.ie/eng/services/publications/performancereports/performance-profile-july-september-2020.pdf

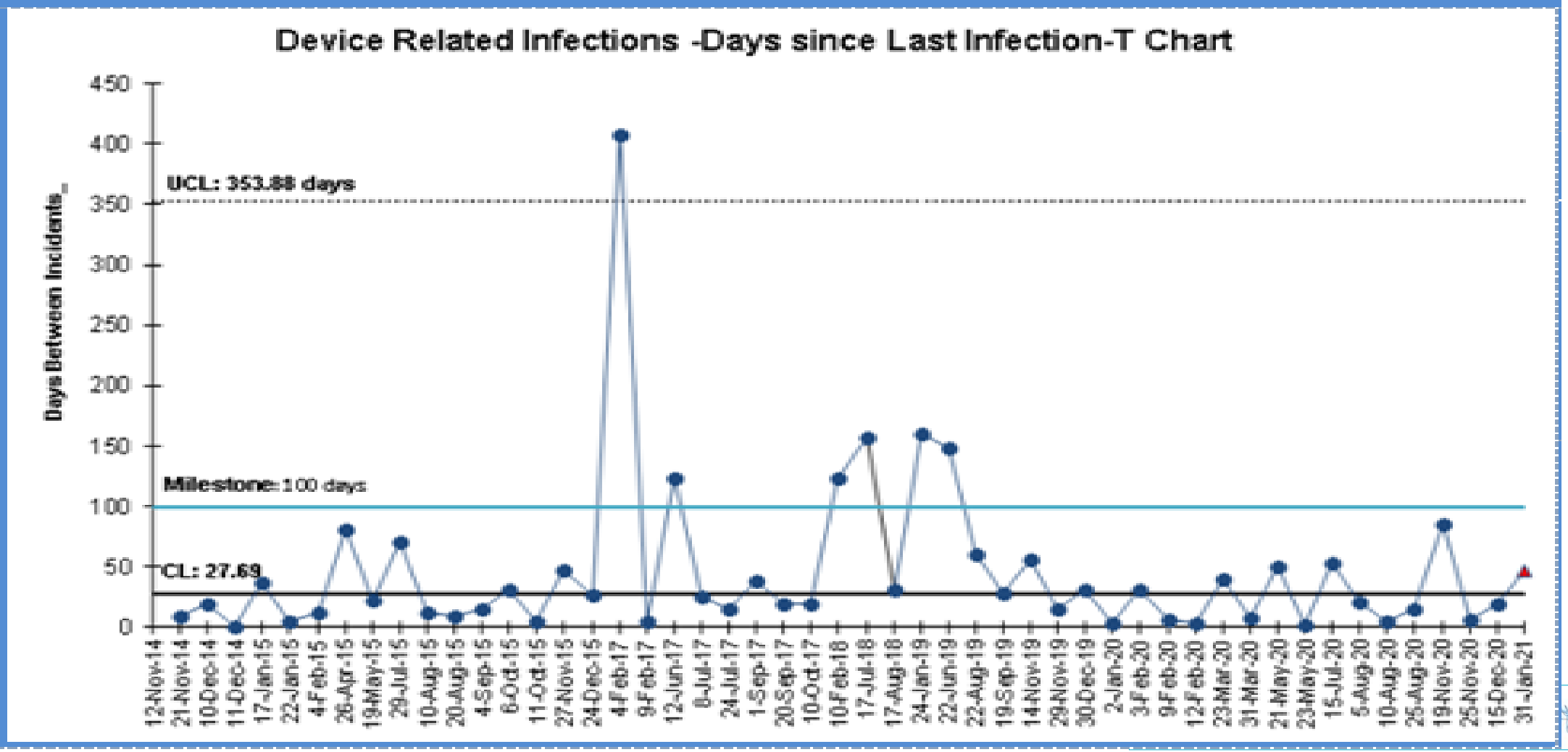
Some examples from around Ireland

Image: https://maproom.net/shop/outline-map-of-ireland/

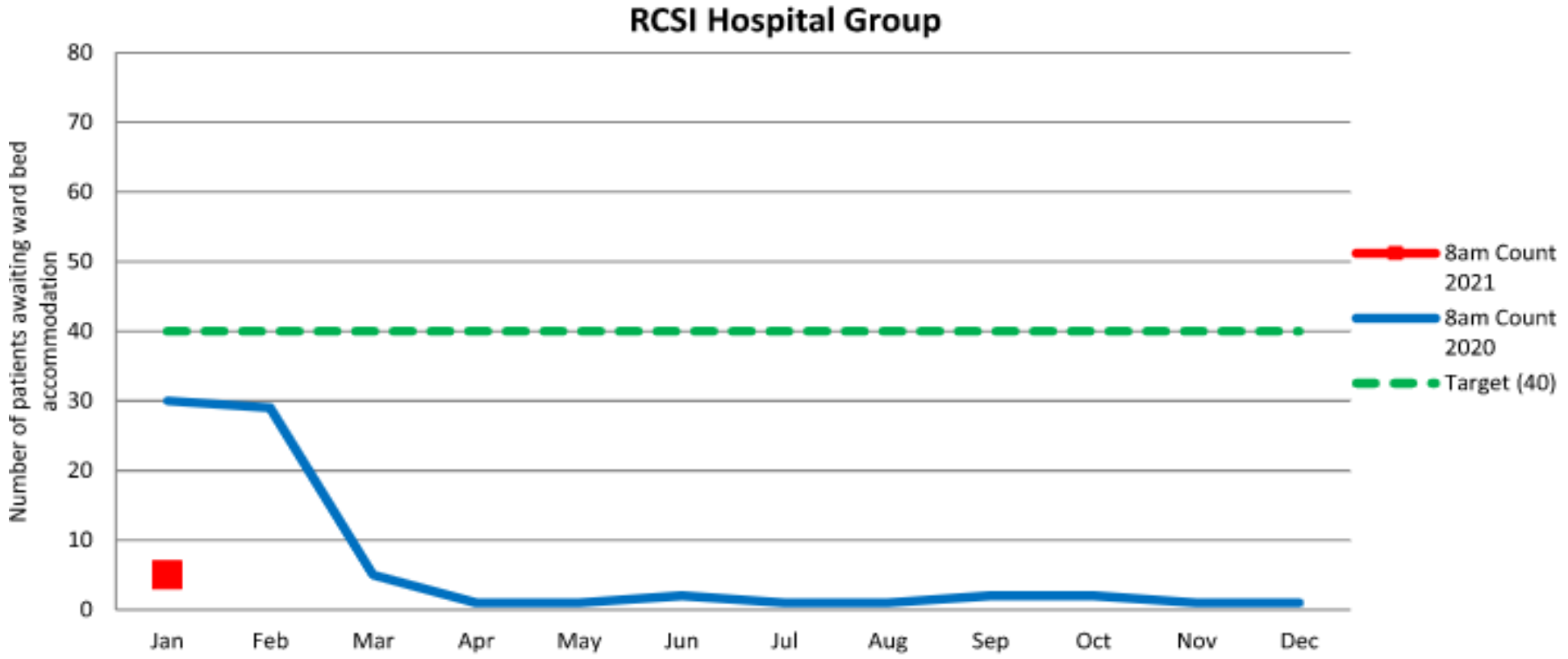
Children's Health Ireland at Temple Street: Quality and Safety Quadrant; Days since last infection

Device Related Infections – Days Since Last Infection T Chart

SAFE CARE & SUPPORT



Number of patients awaiting ward bed accommodation: RCSI Hospital Group

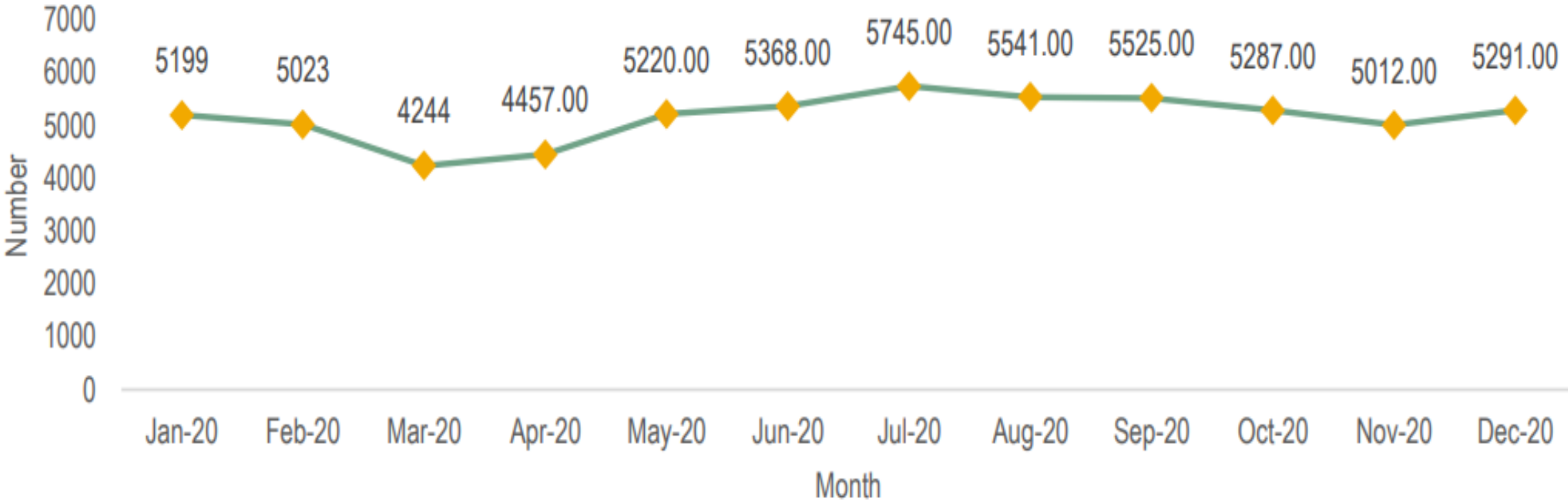


•83% reduction in average number of patients awaiting ward bed accommodation in ED 2021 / 2020 for January **(total count reduction 84% n=790 Jan-Jan)**

•An average daily count of **5** demonstrated for January 2021 (**Target 40 surpassed**)

Hospital Patient Safety Indicator Report: University Hospital Limerick-December 2020

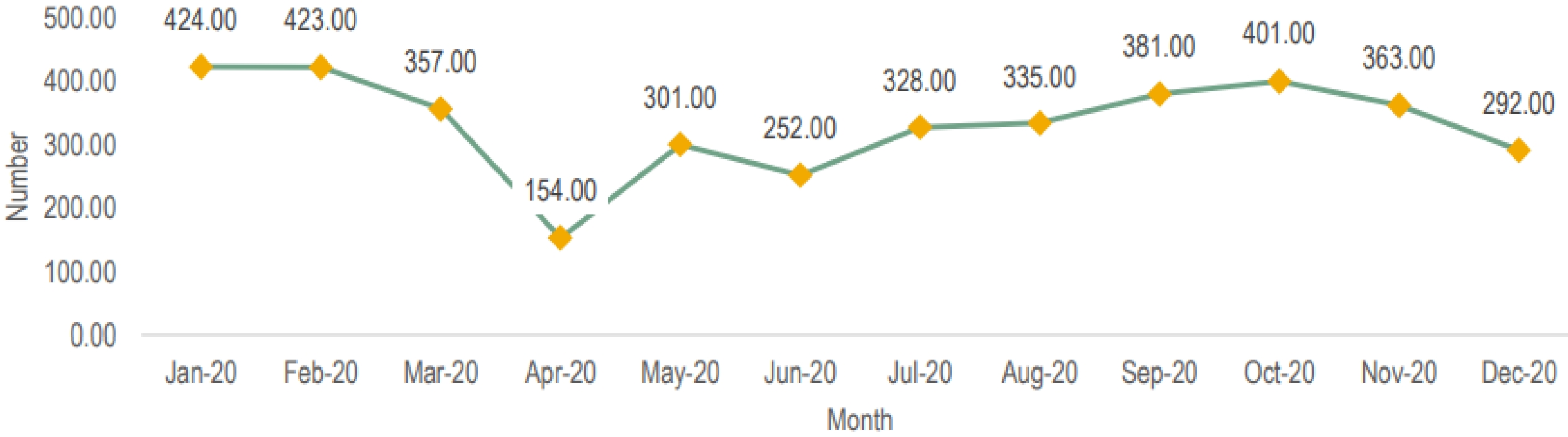
Number of new ED attendances



https://www.hse.ie/eng/services/list/3/acutehospitals/patientcare/hospital-patient-safety-indicators-reports/university-of-limerick-hospital-group/university-hospital-limerick-hpsir-dec-2020.pdf

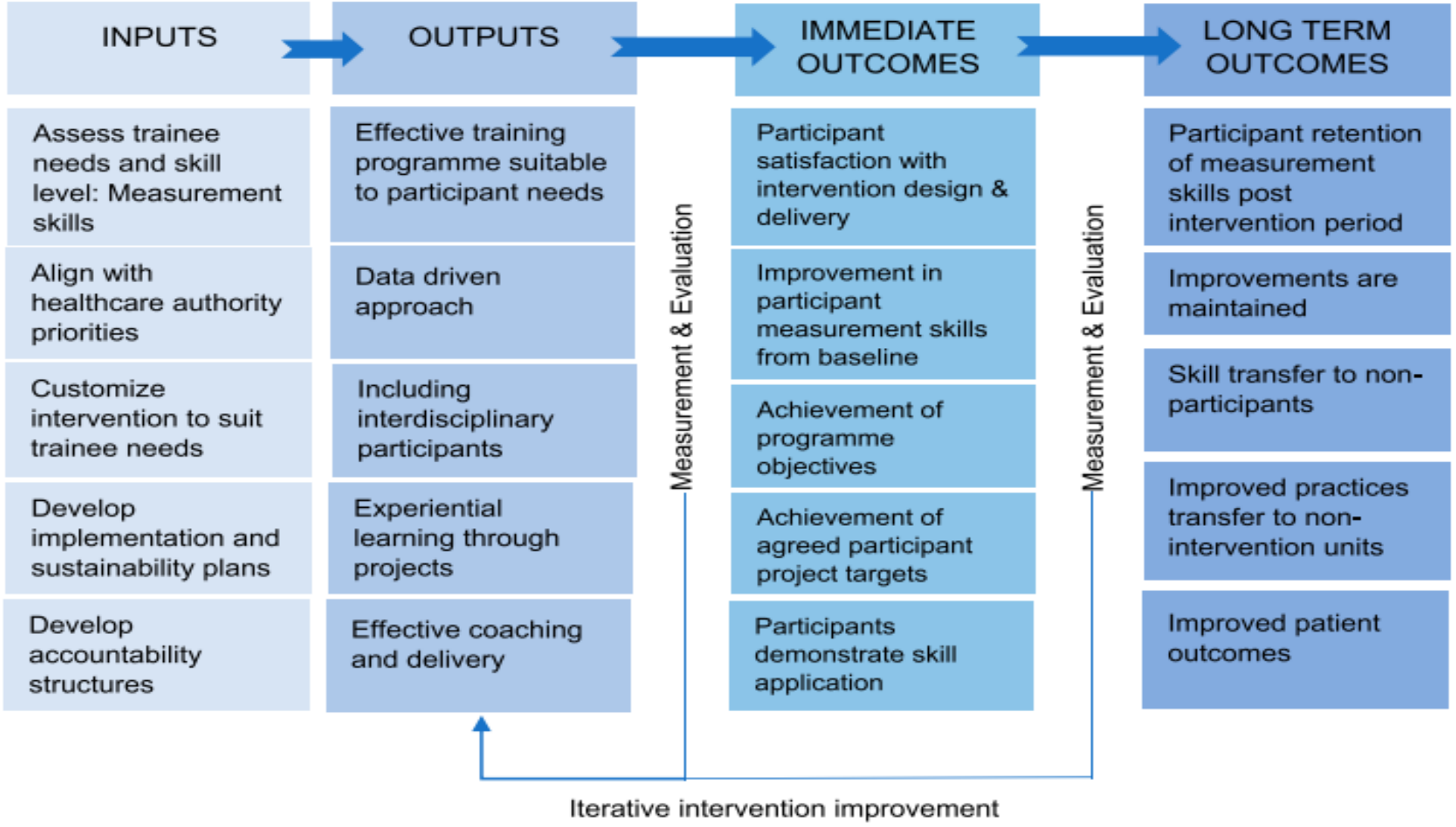
Hospital Patient Safety Indicator Report: Saint John's Hospital Limerick-December 2020

Number of inpatient discharges



https://www.hse.ie/eng/services/list/3/acutehospitals/patientcare/hospital-patient-safety-indicators-reports/university-of-limerick-hospital-group/st-john-s-hospital-limerick-hpsir-dec-2020.pdf

Systematic Review and Narrative Synthesis: Determinants of the Effectiveness and Sustainability of Measurement-Focused Quality Improvement Trainings



Links to Evidence for Improvement Resources

- **Systematic Review and Narrative Synthesis: Determinants of the Effectiveness and Sustainability of Measurement-Focused Quality Improvement Trainings (**https://journals.lww.com/jcehp/Abstract/9000/A_Systematic_Review_and_Narrative_Synthesis_.99858.aspx**)**
- **COVID SPC Paper (**https://www.hse.ie/eng/about/who/qid/covid-19-qi-learning/resources-developed-to-support-the-national-covid19-response/understanding-variation-in-key-covid-19-indicators-in-ireland-using-statistical-process-control-shewhart-charts.pdf**)**
- **Presentations** (https://www.hse.ie/eng/about/who/qid/evidence-for-improvement/measurementimprovement/mit-presentations.html)
- **Publications** (https://www.hse.ie/eng/about/who/qid/evidence-for-improvement/measurementimprovement/mit-publications.html)
- **Measurement for improvement curriculum** (https://www.hse.ie/eng/about/who/qid/evidence-for-improvement/measurementimprovement/mfi curriculum.html)
- **Measurement for improvement resources and templates** (https://www.hse.ie/eng/about/who/qid/evidence-for-improvement/measurementimprovement/mit-resources.html)
- **Videos** (https://www.hse.ie/eng/about/who/qid/evidence-for-improvement/measurementimprovement/videos.html)
- **Glossary of measurement for improvement terms** (https://www.hse.ie/eng/about/who/qid/evidence-for-improvement/measurementimprovement/glossary-mit-terms.html)
- **Board on Board with Quality of Clinical Care- Mater Hospital case study** (https://www.hse.ie/eng/about/who/qid/governancequality/boardquality/hseboardonboard.pdf)
- **Bringing the Board of Directors on Board with Quality and Safety of Clinical Care- Temple Street Children's Hospital case study** (https://www.cuh.ie/wp-content/uploads/2018/08/TSCUH-and-QID-Case-Study-and-Toolkit-FINAL.pdf)
- **National Quality Improvement Team Self-Evaluation Guide** (https://www.hse.ie/eng/about/who/qid/nationalsafetyprogrammes/national-qi-self-evaluation-guide.pdf)

Thank you for listening!

- Thank you Zuneera for her help on the slides
- Thank you the QI evidence team Grainne, Emma, Nicola and Gemma
- Thank you Michael Carton and Eilis Murphy for their input
- Thank you all other data advocates who have produced the great information shown today.

COVID Data Summary

Developed for: HSE Executive Management Team Meeting, used nationally and also by regions

Purpose:

- Supporting effective decision making at national level
- Highlighting signals in the data (in particular periods of rapid growth in cases and hospitalisations) that were not obvious from other analysis
- Enhancing understanding of variation in the data for the early identification of future signals in data

Background & Significance:

- Applying standard SPC charts to pandemic data can be challenging, due to the often rapidly changing trajectory of the data
- A new, more sophisticated methodology for applying SPC methodology to COVID data developed by a team of leading international experts in QI
- The National QI Team collaborated with this team of experts to apply this approach to Irish data

Systematic Review and Narrative Synthesis: Determinants of the Effectiveness and Sustainability of Measurement-Focused Quality Improvement Trainings

Unique systematic review focusing on continuing education for health care professionals in data skills for QI

Purpose:

- To define effectiveness and sustainability of QI programs for health care professionals containing a measurement skills component and to identify barriers and facilitators to effectiveness and sustainability.

Major Outcomes:

- Identification and categorization of basic, intermediate and advanced data skills reported in studies
- Staff engagement, strategic approach to QI, organizational support, intervention design, communication, accountability, leadership support, and learning networks influence effectiveness and sustainability of QI programs
- Measurement emerged as a critical element of QI training programs, which enables health care professionals and organisations to demonstrate effectiveness of improvement efforts and sustain improvements in the long run

Available at: https://journals.lww.com/jcehp/Abstract/9000/A_Systematic_Review_and_Narrative_Synthesis_.99858.aspx

The National Quality Profile

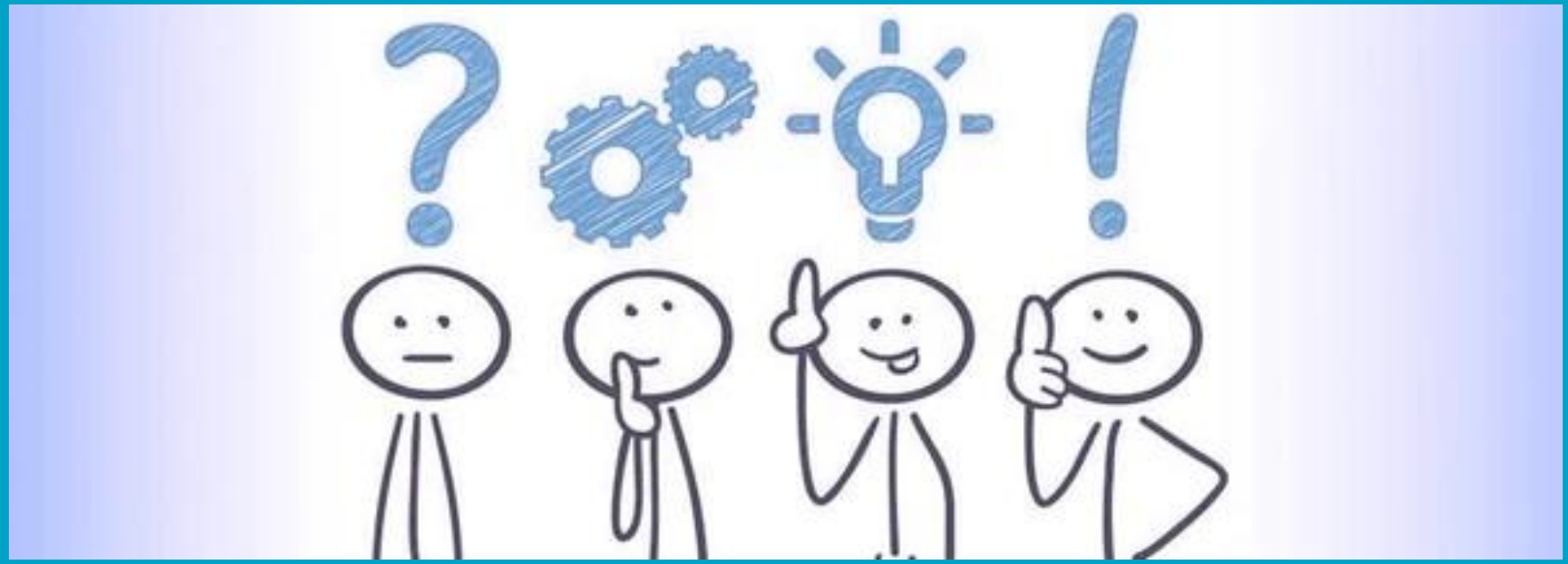
Developed for: HSE Board Safety & Quality Committee

Purpose:

- Providing a picture of quality of care to support the Safety and Quality Committee in leading the organisation in improving quality
- Supporting oversight and decision making by analysing and presenting data over time and between services and the performance across key indicators using Statistical Process Control (SPC) charts
- Helping members understand the variation in the data and guiding on interpretation and use of SPC charts

Background & Significance:

- Using a Co-design process with HSE directorate to develop a standing agenda item which provides a picture of quality of care consisting of a patient and staff story and the HSE Quality Profile
- Presenting key indicators across seven domains of quality: Safe, Effective, Person-Centred, Timely, Efficient, Equitable, and Better Health & Wellbeing



TIME FOR QUESTIONS AND DISCUSSION

Let us know how we did today ….

New feature: Short feedback form after the session, please help us to improve our QITalktime Webinars

A window will pop up before logging out with a few short questions

We really appreciate your time, thank you

Upcoming Webinars: Dates for your diary ….

QI TALK TIME
Building an Irish Network of Quality Improvers

Dates	Topics	Speakers
20 April	Communicating in a Virtual World	Wini Ryan and Prof Peter Gillen
4 May	Learning from COVID-19 through stories	Zuneera Khurshid, National QI Team/UCD
18 May	Whole system approach to QI	Dr Amar Shah, Chief Quality Officer at East London NHS Foundation Trust (ELFT)

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Missed a webinar – Don't worry you can watch recorded webinars on HSE National QI Team- QITalktime page: https://www.hse.ie/eng/about/who/qid/resourcespublications/qitalktime.html